AHCCCS

Arizona Health Care Cost Containment System

Five-Year Strategic Plan
Fiscal Year 2009 – 2013
January 1, 2008

AHCCCS • 801 East Jefferson, Phoenix, AZ 85034 • 602 417 4000 • www.azahcccs.gov

Janet Napolitano, **Governor**
***Anthony D. Rodgers*, Director**

801 East Jefferson, Phoenix AZ 85034
PO Box 25520, Phoenix AZ 85002
***phone** 602 417 4000*
www.azahcccs.gov

AHCCCS

Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

January 1, 2008

Dear Arizonans:

I am pleased to present to you a copy of the AHCCCS strategic plan for State Fiscal Years 2009-2013. As in previous years, the plan was developed within the context of Arizona's economy and with a view toward the future health and economic well being of Arizona citizens. Our strategic plan, which is revised and updated annually, describes the role of AHCCCS in this evolutionary process.

Demand by working Arizonans for AHCCCS health care coverage is closely tied to the economic well-being of the state. AHCCCS programs continue to serve approximately 17% of Arizona's population. The substantial number of Arizonans covered by AHCCCS health insurance creates both short and long term concerns.

- The short-term focus is to ensure sufficient federal and state funding to meet a sizeable membership.
- The long-term focus is to manage the rise in medical costs and increase public and private health care coverage options without negatively impacting other essential state services, while improving health care quality and access to primary, preventive, and community-based services.

Our strategic plan describes how we intend to address the following key concerns:

- Health Care Costs
- Health Care Quality
- The Uninsured
- Organizational Capacity

Historically, AHCCCS has received high marks on both management and program outcomes. Our strategic plan is intended to carry that positive momentum forward to meet future challenges.

The strategic plan is also located on our web site at:

http://www.azahcccs.gov/Publications/StrategicPlanning.

Sincerely,

Anthony D. Rodgers
Director

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is a public-private partnership that uses federal, state, and county funds to provide health care coverage to the state's acute and long term care Medicaid population, low-income groups, and small businesses. Unlike programs in other states that rely solely on fee-for-service reimbursement, AHCCCS makes prospective capitation payments to contracted health plans responsible for the delivery of care. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and encourages prevention and the coordination of quality care. Currently, over one million individuals, approximately 17% of Arizonans, receive health care coverage through AHCCCS.

Arizona is one of the fastest growing states in the nation, with a changing population and a changing economic climate. The increased population, coupled with a proliferation of low-wage jobs and increasing health insurance costs, has contributed to significant growth of the AHCCCS program. Moreover, this growth reflects a change in the AHCCCS population from one comprised primarily of non-working welfare recipients to one comprised of the working poor. The AHCCCS Strategic Plan should be viewed as a dynamic document that will be modified over time as the agency repositions to address shifting issues and challenges. The Plan should serve as a framework for ongoing planning, prioritizing, and budgeting.

The AHCCCS Strategic Plan for 2009-2013 begins with a description of the agency's mission and vision, an overview of the programs offered, and a summary of the environment in which these matters take place. The Plan then outlines four interrelated issues, each of which is discussed in terms of goals, recent accomplishments, strategies, and performance measures. Finally, it offers strategic initiatives that exemplify the importance and integration of all four strategic issues. The cross-cutting initiatives relate to significant populations impacted by the strategic issues described within.

Strategic Issues

Issue #1 – Health Care Costs

Health Care Costs relates to a variety of cost drivers including general price inflation, population growth, provider supply and market structure, operating costs, health status, and changes in technology. As AHCCCS expenditures consume an increasing proportion of state general funds, strategies may include restructuring provider rates to improve equity and ensure continued access to care, offering more cost-effective purchasing options (e.g., for specialized services), and maximizing non-state funding sources.

Issue #2 – Health Care Quality

Health Care Quality relates to a variety of factors that include both the scientific and personal aspects of receiving care. Preventive care, effective disease management programs, availability of providers, and accessibility to necessary services are all key components in the delivery of quality care. Strategies that may lead to improvements in quality and result in an overall reduction in costs include the use of centers of excellence, use of evidence-based treatment

guidelines, support of graduate medical education (particularly in rural areas), continued emphasis on preventive care, and facilitation of telemedicine networks.

Issue #3 – The Uninsured

The Uninsured is an important issue to Arizona. While over 1.2 million Arizonans are without health care coverage, most of them are employed. However, either they are not offered coverage by their employer or they are unable to afford what is offered. Lack of insurance can lead to significant consequences, not only for the uninsured, but also for the state economy and the health care delivery system. The cost of uncompensated care includes reductions in accessibility and quality as well as higher costs for other consumers. Strategies to reduce the uninsured include raising awareness of AHCCCS programs, especially for children.

Issue #4 – Organizational Capacity

Organizational Capacity is a key component of the agency's strategic plan. To effectively address the challenges related to organizational capacity and to improve management of limited resources, AHCCCS will address both information technology (e.g., system architecture and software) and workforce planning issues (e.g., succession planning for an aging workforce, reduction of turnover, and continuation of a Virtual Office environment). Given the ever-increasing need to do more with less, attention to these issue offers opportunities to serve both the agency and its customers more efficiently.

Strategic Initiatives

Responding to a Growing Aging Population

The time is approaching when the baby boomer generation will turn 65 and create the most dramatic age shift in history. Because of its sheer numbers, this cohort has the potential to place a significant strain on government resources and health system capacities. Arizona (AHCCCS in particular) must plan now for this imminent challenge. The initiative describes the demographic picture, outlines the salient issues and their impact on AHCCCS, and recommends approaches to serving a growing aging population. Recommendations center on coordinating and managing care, ensuring an adequate and appropriate provider network, and considering the impact of demographic aging in all health care preventive efforts and quality improvement processes.

Native American Health Care

Arizona is home to nearly 278,000 Native Americans, nearly half of whom are enrolled in AHCCCS. Historically, the burden of illness among Native Americans has been significantly greater than that of the general population. Thus, in its role as a major source of health care services to this population, AHCCCS is committed to developing strategies that have the potential to positively impact health status. The initiative presents population demographics, identifies major health concerns, explains barriers to the delivery system, and proposes strategies for intervention. Recommendations center on unique health care needs, availability and accessibility of care, data needs and information exchange.

INTRODUCTION: AHCCCS Today and Tomorrow

Vision:
Shaping tomorrow's managed health care… from today's experience, quality and innovation.

Mission:
Reaching across Arizona to provide comprehensive, quality health care for those in need.

Core Values:
Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork and Leadership

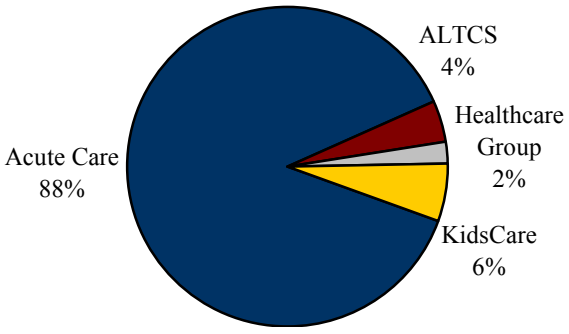
Overview

The Arizona Health Care Cost Containment System (AHCCCS), which serves as the state's Medicaid agency, is a health care program primarily targeted at serving low-income Arizonans. The program is a model public-private collaboration that includes the state and its counties, the federal government, and health plans and providers from both the public and private sectors. In State Fiscal Year (SFY) 2007, AHCCCS provided health care coverage to over 1.1 million Arizonans. The Administration's main responsibilities include setting policy and controls for eligibility determination, member enrollment management, quality assurance of medical care, provider and plan oversight, federal and state financial management and reporting, and procurement of contract providers. AHCCCS uses both a prepaid capitated and fee-for-service (FFS) payment system, but the majority of payment arrangements are prepaid, providing quality health care while managing costs at the same time.

"In SFY 2007, AHCCCS provide health care coverage to over 1.1 million Arizonans…"

AHCCCS has operated under an 1115 Research and Demonstration Waiver since 1982 when it became the first statewide Medicaid managed care system in the nation. The waiver program, which is renewable every five years, was reauthorized this year by the Centers for Medicare and Medicaid Services (CMS). It will not require renewal again until October 1, 2011.

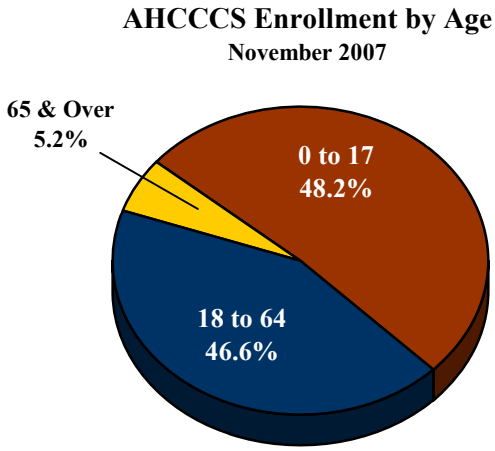
AHCCCS and HCG Enrollment
1,106,862 Members as of Nov 2007



AHCCCS oversees four main programs:

- Acute care services (Acute)
- KidsCare
- Arizona Long Term Care System (ALTCS)
- Healthcare Group (HCG)

Acute Care



As of November 2007, the Acute Care program provides a comprehensive array of health care services to 972,034 enrolled members (excluding KidsCare). The majority of the acute care population includes children and pregnant women who are determined eligible for Medicaid (Title XIX). The majority of eligible acute care members receive their care through contracted AHCCCS health plans. Native Americans who are eligible for acute care services may opt to receive their services through Indian Health Services (IHS) or an AHCCCS contracted health plan. AHCCCS also administers an emergency services program for individuals who, except for their immigration status, would qualify for Medicaid.

KidsCare

The Title XXI State Children's Health Insurance Program (SCHIP), which is referred to as KidsCare, provides affordable insurance coverage for low-income families. Children under the age of 19 may qualify for the program even if their family's income exceeds Medicaid income standards. As of November 2007, 65,049 children were enrolled in KidsCare. Parents pay a monthly premium based on income to obtain coverage. The program maximizes federal contributions, realizing a federal contribution of almost $3 for every $1 spent by the state. The upper income limit for program eligibility is 200% of the federal poverty level (FPL). With the exception of Native American children, who may elect to receive their care through IHS, children enrolled in KidsCare are assigned to managed-care health plans. Children enrolled in KidsCare presently receive the full array of services offered to children enrolled with Medicaid.

Long Term Care

The Arizona Long Term Care System (ALTCS) program provides acute care, behavioral health care, long term care and case management services to individuals at risk of institutionalization (i.e., elderly, disabled, and individuals with developmental disabilities). As of November 2007, 44,445 members were enrolled in the ALTCS program. Whereas these ALTCS members account for only 4% of the AHCCCS population, they account for approximately 27% of the costs. The program emphasizes delivery of care in alternative residential settings. Like the Acute Care program, elderly and physically disabled members of all ages receive their care through contracted ALTCS plans referred to as "program contractors." Tribal members may choose fee-for-service (FFS) providers, with tribal case management, or enroll with a program contractor, and members with developmental disabilities are served through the Arizona Department of Economic Security (ADES), Division of Developmental Disabilities.

Healthcare Group

Healthcare Group (HCG) was created to provide affordable premium-funded health care to small businesses with 50 or fewer employees and to political subdivisions within the state. As of October 2007, there were 9,136 firms and 25,589 members enrolled in HCG. Coverage is offered in all 15 counties.

Other Programs

In addition to the four main programs previously described, AHCCCS administers a Freedom to Work program, SSDI Temporary Medical Coverage, and a Breast and Cervical Cancer Treatment program. These are acute care programs and included in previous acute care numbers. AHCCCS also holds contracts with a number of public and private entities that provide a variety of services:

- Behavioral health services, provided by the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services.
- Acute health care services for children in foster care, provided by the Arizona Department of Economic Security (ADES), Comprehensive Medical and Dental Program.
- Services for children with chronic conditions provided through ADHS, Children's Rehabilitative Services (CRS).
- Administrative services such as eligibility determination performed by ADES.
- Claims payments associated with the Medicaid School Based Claiming program that is administered by a private third party administrator.

The Environment: What is AHCCCS Confronting?

To understand the context in which the AHCCCS Strategic Plan was developed, it is important to understand the current environment in which Arizona health care delivery systems operate and the challenges that these systems will face in the future. A host of factors must be considered, including demographic characteristics, state of the economy, and the dynamics of the health care marketplace. These factors are summarized below and within the context of each strategic issue.

Demographic Characteristics of Arizona

Although Arizona is similar to other states in some demographic characteristics (e.g., age, gender), it is unique in others (e.g., growth, ethnicity). A variety of demographic factors will impact the way health care services are designed and delivered in Arizona:

Key Demographics:
One of fastest growing states in the nation
Large Hispanic and Native American populations
Uninsured rate exceeds national average

- Arizona is ranked second by the U.S. Census Bureau as one of the fastest growing states, following Nevada. The population is expected to increase 108% between 2000 and 2030, to 10.7 million people. Between 2000 and 2006 alone, Arizona growth is estimated to have grown over 20%, compared to a 6% increase nationwide during the same period.
- Arizona has a large Hispanic population (32% v. 15% nationwide) as well as a large Native American population (5% vs. 1% nationwide) (U.S. Census Bureau). Both groups also have high rates of uninsured and unemployment.
- The percentage of uninsured in Arizona is 20% compared to 16% nationwide. Hispanics account for 57% of all uninsured non-elderly Arizonans; and, of all non-elderly Hispanics in Arizona, approximately 37% are uninsured (Kaiser, states (2005-2006) U.S. (2006)).
- Arizona is one of four U.S.-Mexico Border states, a fact that contributes to its large population of non-citizens, which is estimated at 11%; among children, 6% are non-citizens (Kaiser).
- The number of Arizonans over age 65 will grow from approximately 850,000 in 2006 to 1.6 million in 2020, or 14% vs. 18%, respectively (Population Projections, Arizona Department of Economic Security).

Arizona Economy

There is a significant demand for government-supported programs, particularly those that provide health care. Whereas small businesses make a substantial contribution to the proliferation of low-wage jobs, they frequently fail to offer employer-sponsored insurance and, ultimately, create a greater demand for public programs. Although there is growing concern about the effects this increased demand will have on the General Fund, the amount of federal, state, and local dollars distributed by AHCCCS has positively impacted the state's overall economy, particularly in relation to the health sector.

Health Care Marketplace

The challenge to meet the demands for medical care is compounded by rising health care costs that now exceed the overall rate of inflation by approximately 3.5 percentage points and the increase in workers' earnings by nearly 2.5 percentage points (Kaiser Family Foundation). Despite such increases, AHCCCS managed costs effectively during the most recent contract year. AHCCCS health plan weighted average capitation rates increased approximately 6.0% (6.9% for Acute Care, 3.7% for Long-Term Care). National private sector premium increases were reported to be approximately 6.1% (Kaiser Family Foundation.).

Recent data indicate that total health care spending represents approximately 16% of the gross domestic product (GDP) (National Coalition on Health Care, 12/13/06). Common factors cited as contributing to increased health care costs include: greater utilization of services; hospital cost inflation; drug costs; acceleration of new medical technologies; and medical liability.

At the same time, in reaction to a strong national consumer backlash against "managed care," the private health care delivery model has shifted away from health maintenance organizations (HMOs) to preferred provider organizations (PPOs) that offer consumers greater choice and flexibility. This trend is evident in Arizona, despite the state's history of high HMO penetration. In addition to PPOs, alternative health care benefit models appearing in the market include consumer-driven plans, medical savings accounts, and high-deductible alternatives.

Common Factors that Contribute to Increased Health Care Costs:
Greater utilization of health care services
Inflation in hospital, physician, and prescription drug costs
Acceleration of new medical technologies
Medical liability

Availability and access to needed medical care is an increasing challenge for the consumer in Arizona. Historically, shortages of health care professionals (particularly specialists) and hospital capacity primarily affected the rural areas of the state. Currently, these shortages are affecting rapidly growing urban areas as well. In short, the volume of medical professionals is not keeping pace with the population growth. In addition, rising malpractice insurance costs have led to changes in physician practices, creating medical coverage issues, excessive emergency department utilization, and a reduction in the number of professionals willing to care for high-risk cases.

Finally, some continuing trends that affect the health care market include:

- An increase in consumers' activism and involvement in the selection of their own treatment and drug preference.
- Changing demographics.
- A decrease in employer-sponsored insurance.
- National reform efforts for Medicare/Medicaid due to high federal deficits.
- National promotion of e-health.

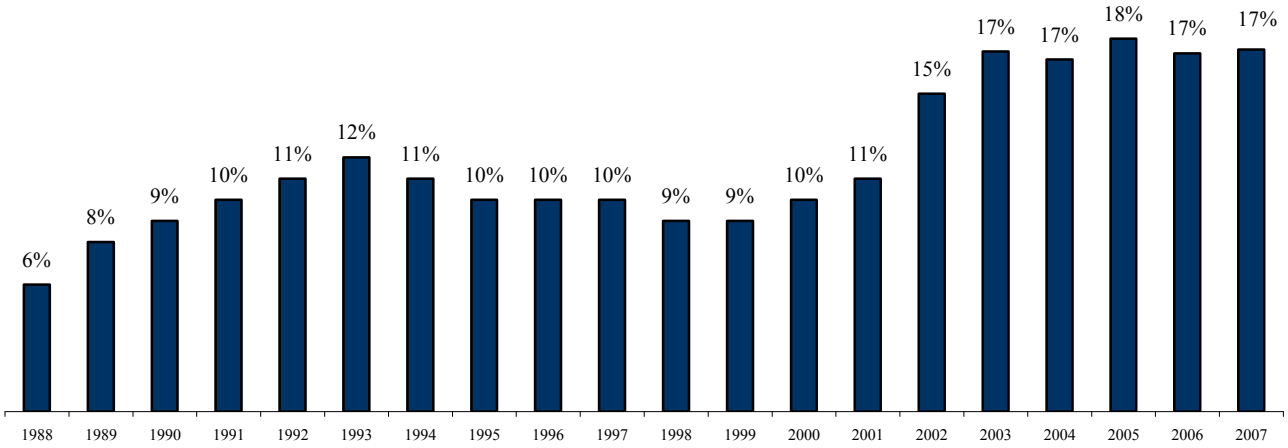
Growth of AHCCCS

Economic factors and voter-initiated changes in eligibility requirements (e.g., Proposition 204) contributed to the more recent program growth reflected in the figure below, which shows annual changes in the AHCCCS population during the last 20 years. Expansion programs that have extended eligibility limits to 100% of FPL, combined with significant population growth, a proliferation of low-wage jobs, and higher costs for health insurance, have contributed to AHCCCS program growth.

Moreover, these factors have changed the appearance of the AHCCCS population from one comprised primarily of non-working welfare recipients to one including low-wage workers. Coverage of low-wage, uninsured workers reduces illness, increases workplace productivity, and ultimately leads to economic benefits. Affordable health insurance options, as alternatives to publicly subsidized care, are essential to Arizona's economy in the long run. A stable and

appropriately financed health care delivery system attracts new business to the state and ultimately benefits everyone.

PERCENT OF ARIZONANS ON AHCCCS



All data are as of the month of July. Does not include Healthcare Group or Medicare Cost Sharing populations.

AHCCCS Strategic Plan

This strategic plan sets forth a new vision for AHCCCS, positioning the agency to more effectively and efficiently meet the health care needs of Arizonans in the twenty-first century. Within the context of the ever-changing health care environment, AHCCCS continues to expand its focus on an integrated, value-driven health care transformation.

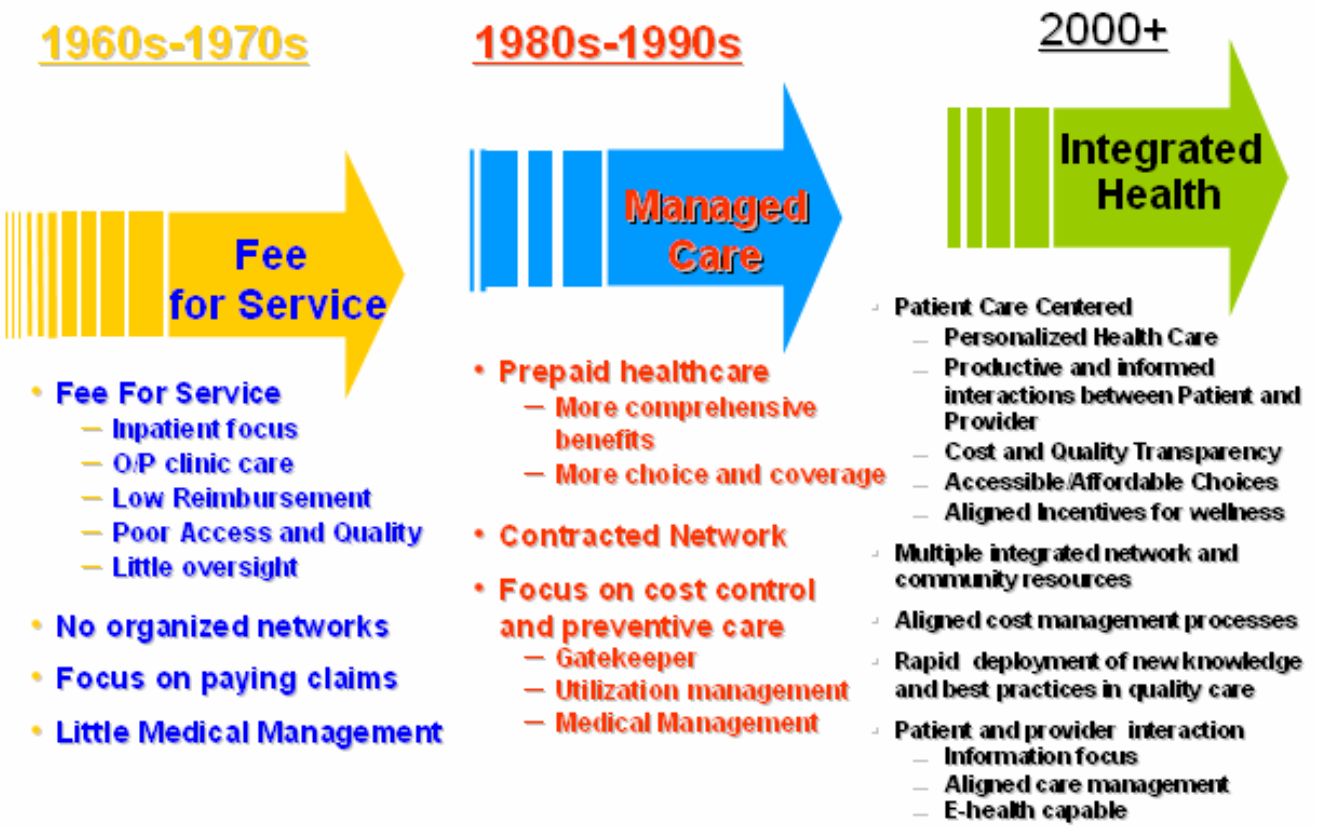
To achieve its movement towards health care transformation, AHCCCS must address four strategic issues:

Strategic Issue #1:	Health Care Costs
Strategic Issue #2:	Health Care Quality
Strategic Issue #3:	The Uninsured
Strategic Issue #4:	Organizational Capacity

Within this document, background information is provided to support the goals and strategies that address each specific issue. It is important to remember that these issues are interdependent. The strategic issues overlap, and effective strategies applied to one issue are often beneficial to another. Because of their interdependence, each strategy builds on the other and each supports the overall plan.

Ultimately, AHCCCS' expectation is that, in addressing each of the strategic issues above in an overarching manner, Arizona will continue to mature in its transformation from managed health care to integrated and value-driven health care, as outlined below.

Managing Health System Transformation in Arizona



Value Driven Health Care

With rising health care costs growing at over 10% annually, all Americans are feeling the adverse effects. Employers cannot keep up with these costs and are obligated to pass them on to employees, potentially causing employees to experience net decreases in pay. To help control these costs, health care consumers will need to choose more "valuable" health care (i.e., quality care delivered in an effective and cost efficient manner). Quality care is more than accessibility to services; it is the right care delivered at the right time and in the right setting.

"Every American should have access to a full range of information about the quality and cost of their health care options."

Secretary Mike Leavitt
U.S. Department of Health and Human Services

For consumers to select valuable health care, they need more information about its cost and quality. Currently, health care consumers are making decisions based on anecdotal evidence whereas retail industry prices are published on every shelf. Because of the availability of quality comparison reports (e.g., *Consumer Reports)*, retail shoppers can make decisions in an industry that is transparent. Unfortunately, the

availability of comparable healthcare information is limited; and, that which is available, is often difficult to interpret.

To address the limitation of information, President Bush signed executive order #13410 in August 2006 to improve the transparency of America's Health Care System and, ultimately, to empower Americans to find better value and better care (www.whitehouse.gov/news/releases/2006/08/20060822.html). Secretary Mike Leavitt of the U.S. Department of Health and Human Services is implementing the President's Executive Order by creation of a "Value Driven Health Care" initiative.

Value Driven Health Care has four cornerstones:

1. *Interoperable Health Information Technology:* an interconnected system of healthcare information between physicians, hospitals, pharmacies, and other healthcare providers and payers. This interconnectivity will enable the exchange of clinical data, laboratory tests, and radiological images, ultimately resulting in quality of care improvements. Other expected results include reductions in redundant laboratory and radiology procedures as well as decreases in associated healthcare costs.

2. *Transparency of Quality:* accessibility to information on the quality of care.

3. *Transparency of Cost:* accessibility to information on the cost of care.

4. *Incentives for High Value Care:* encouragement to Medicaid beneficiaries to pursue high-value care and incentives for healthcare providers to deliver high-value care.

Value Driven Health Care at AHCCCS

As the largest purchaser of health care services in Arizona, AHCCCS has substantial influence on the state's health system. It is appropriate, therefore, that AHCCCS pursue Value Driven Health Care. Following the direction of President Bush and Secretary Leavitt, AHCCCS' role is to support Value Driven Health Care as a means of improving the health care of AHCCCS members and all Arizonans.

AHCCCS is currently making significant progress regarding the Value Driven Health Care Initiative. AHCCCS applied for and was awarded two Medicaid Transformation Grants from the Center for Medicare and Medicaid Services (CMS) to transform the current Medicaid system. The first grant, Health Information Exchange/Electronic Health Record utility (HieHR utility), was awarded $11.8 M in February 2007. The HIeHR utility will address the first cornerstone of interoperable health information systems mentioned above.

A second grant, awarded in November 2007 for a total of $4.4 million, is intended for the development of a Value Driven Decision Support Tool Box. This Tool Box focuses on the multimedia delivery of transparency information to help overcome literacy and linguistic barriers.

Quality and cost information will be presented in tandem and at key decision points. Evidence-based medical guidelines will also be included. Other measurements of quality and cost, both for AHCCCS external and internal customers, are currently in development, but will likely include Healthcare Effectiveness Data and Information Set (HEDIS) measures and comparative episode-of-care analytics. Chronic care measures for conditions such as diabetes and asthma will also include rates of emergency room visits, inpatient admissions, and mortality. As laboratory values become available from the HIeHR utility, some quality measures will integrate lab values, such as the percentage of persons with diabetes that decrease HBA1C or maintain low levels. Essential for the evaluation of clinical data is risk adjustment to compensate for a member's overall risk due to past medical history and demographic factors.

Finally, AHCCCS has submitted plans for physicians' incentives around diabetes care and immunizations for children age two for approval by the state legislature. Other incentives may be proposed at a future date.

Overall, the four cornerstones will be interconnected. The HIeHR utility will serve as a delivery mechanism for transparency and decision support information, and it will also contain information on the Pay-For-Performance (P4P) initiatives. The transparency, decision support, and P4P information will provide additional reasons for providers to choose to participate in the HIeHR utility. The quality measurements in P4P and transparency documents will also be aligned.

For further reading on Value Driven Health Care, please see the following:

http://www.hhs.gov/valuedriven/
http://www.whitehouse.gov/news/releases/2006/08/20060822.html
http://www.deloitte.com/dtt/cda/doc/content/us_chs_pricetransparency_031307.pdf
http://www.leapfroggroup.org/media/file/A_Guide_for_State_Medicaid_Agencies_5.9.07.pdf
http://www.hrsa.gov/medicaid/SMDL07005.htm
http://www.commonwealthfund.org/

STRATEGIC ISSUE #1:
Health Care Costs

National health care costs continue to grow faster than national income, and health spending continues to increase faster than the overall economy (i.e., gross domestic product, or GDP). Since 1970, health care spending has grown at an average annual rate of 9.9%, or about 2.5 percentage points faster than GDP. As a share of the economy, health care has risen from 7.2% of GDP in 1965 to over 16% of GDP currently. It is projected to be 20% of GDP by 2016. Medicaid dollars represent a significant percentage of federal spending and place a major strain on the federal budget. As a result, Medicaid is increasingly more vulnerable to federal cost-cutting strategies. Arizona's population has increased significantly over the past several years and is expected to continue to outpace its current rate of growth. Subsequently, this may increase membership in the AHCCCS program. Although AHCCCS growth promotes spending that ultimately benefits the health sector economy, this growth must be balanced with its impact on the state General Fund.

"Since 1970, health care spending has grown at an average annual rate of 9.9%…"

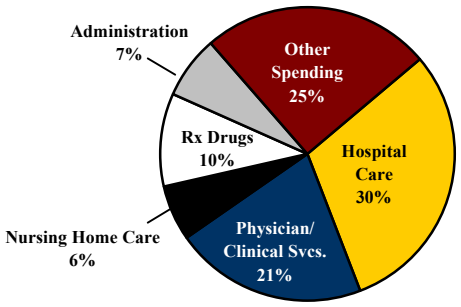
Environmental Scan

Health Care Cost Drivers

Although the growth rate of national health care spending is slowing, it continues to increase twice as fast as the overall economy. U.S. health care spending rose 6.9% to $2.0 trillion in 2005 or approximately $6,700 per person. Future spending projections suggest little change to this pattern. The high rate of growth in health care expenditures can be attributed to a number of key cost drivers including general price inflation, provider supply and market structure, provider operating costs, health status of the population, changes in treatment patterns and technology. The Center for Studying Health System Change reported some interesting trends in health care spending:

- Hospital Spending: Hospital spending accounts for nearly

The Nation's Health Dollar: 2005



Note: Other spending includes dental services, other professional services, home health care, durable medical equipment, over-the-counter medication, public health services, research, and construction.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

one-third of total health care spending and the largest share of national health expenditures. Hospital spending grew 7.9% in 2005, the same rate as in 2004. It is of interest that hospital spending growth by private payers increased 7.6%, whereas public spending increased 8.1%. Increases reflect both higher costs and greater utilization. Nationally, hospital utilization increased from only 0.7% in 2003 to 1.3% in 2004 to 4.5% in 2005 (CMS).

- Prescription Drugs: Prescription drug spending decelerated from an increase of 8.6% in 2004 to an increase of 5.8% in 2005. Contributing factors included a deceleration in Medicaid drug spending and increased use of generic drugs. In contrast to this trend, however, growth in out-of-pocket spending for drugs has outpaced private health insurance spending growth for drugs since 2003 (CMS).
- Physician Care and Clinical Services: Spending on physician and clinical services decelerated slightly from an increase of 7.4% in 2004 to and increase of 7.0% in 2005. Public spending growth decelerated from 9.1% in 2004 to 8.1% in 2005. This is primarily due to a deceleration in Medicaid spending for physician and clinical services, combined with a more modest deceleration in Medicare spending (CMS).

Medical Expenditures

Nationwide

The Kaiser Commission on Medicaid and the Uninsured and Health Management Associates conduct an annual survey of Medicaid officials in all 50 states and the District of Columbia. The most recent findings indicate that Medicaid spending continued to grow slowly in state fiscal year (FY) 2007, after reaching an all-time low in 2006. Furthermore, state revenues remained strong in most states. Specifically, total Medicaid spending growth continued at a higher, but still relatively slow, pace of 2.9% in FY 2007. For FY 2008, state legislatures authorized a growth in total Medicaid spending that averages 6.3%. State revenue growth, although expected to remain relatively strong, is projected to be somewhat less robust than in 2007.

Over the past several years, the state share of Medicaid spending has increased at a more rapid rate than total Medicaid spending. This is because the federal matching rate declined for over half of the states, placing pressure on them to allocate additional state general revenues for the purpose of maintaining current programs.

The Kaiser Commission also reports these additional findings for FY 2007 and FY 2008:

- The two factors primarily responsible for the slowdown in Medicaid spending growth are: (1) low enrollment growth and (2) the impact of Medicare Part D. An economic upturn and the implementation of new citizenship and identity requirements have been cited as reasons for reduced enrollment. The implementation of Medicare Part D transferred responsibility for prescription drugs for "dual-eligible" members (Medicaid recipients also enrolled in Medicare) from Medicaid to Medicare.
- States continue to expand the networks of home and community based services (HCBS) in their long term care delivery systems. A number of (Deficit Reduction Act) DRA options were intended to offer states flexibility in the delivery of long term services and supports.

- An increased number of states has eliminated barriers or adopted new policies designed to improve or expand Medicaid programs in FY 2007 and FY 2008. Improving provider payment rates and expansion of coverage to more of the uninsured is vital in maintaining access to services.
- Many states have made quality improvement a priority. In 2008, 44 states will be using nationally standardized quality measures (i.e., HEDIS, CAHPS) to assess and incentivize performance.

Arizona

Arizona, like the rest of the nation, continues to experience growth in overall program expenditures. In SFY 2007, AHCCCS overall program expenditures (both Medicaid and SCHIP) increased by 4.7%. Program expenditures are affected by a variety of factors including:

- Utilization: Capitation rates are designed to maintain the financial viability of contracted health plans and to reflect utilization and care management. Increases in utilization have a significant impact on capitation rates.
- Long Term Care: Whereas ALTCS members accounted for only 4% of the nearly one million AHCCCS enrollees, they accounted for a disproportionate 27% of total AHCCCS expenditures. As the elderly population increases, AHCCCS faces greater challenges to develop innovative and effective programs that offer quality and cost-effective services.
- Provider Payments: The costs of AHCCCS physician and inpatient hospital services continue to increase. As a result, Contract Year 2008 capitation rates reveal a weighted average increase of 6.0% (6.9% for Acute Care and 3.7% for Long Term Care).

Despite increases in general health care costs, AHCCCS continues to seek creative opportunities to cover the uninsured. Specifically, two programs that make use of non-state funds exemplify these efforts.

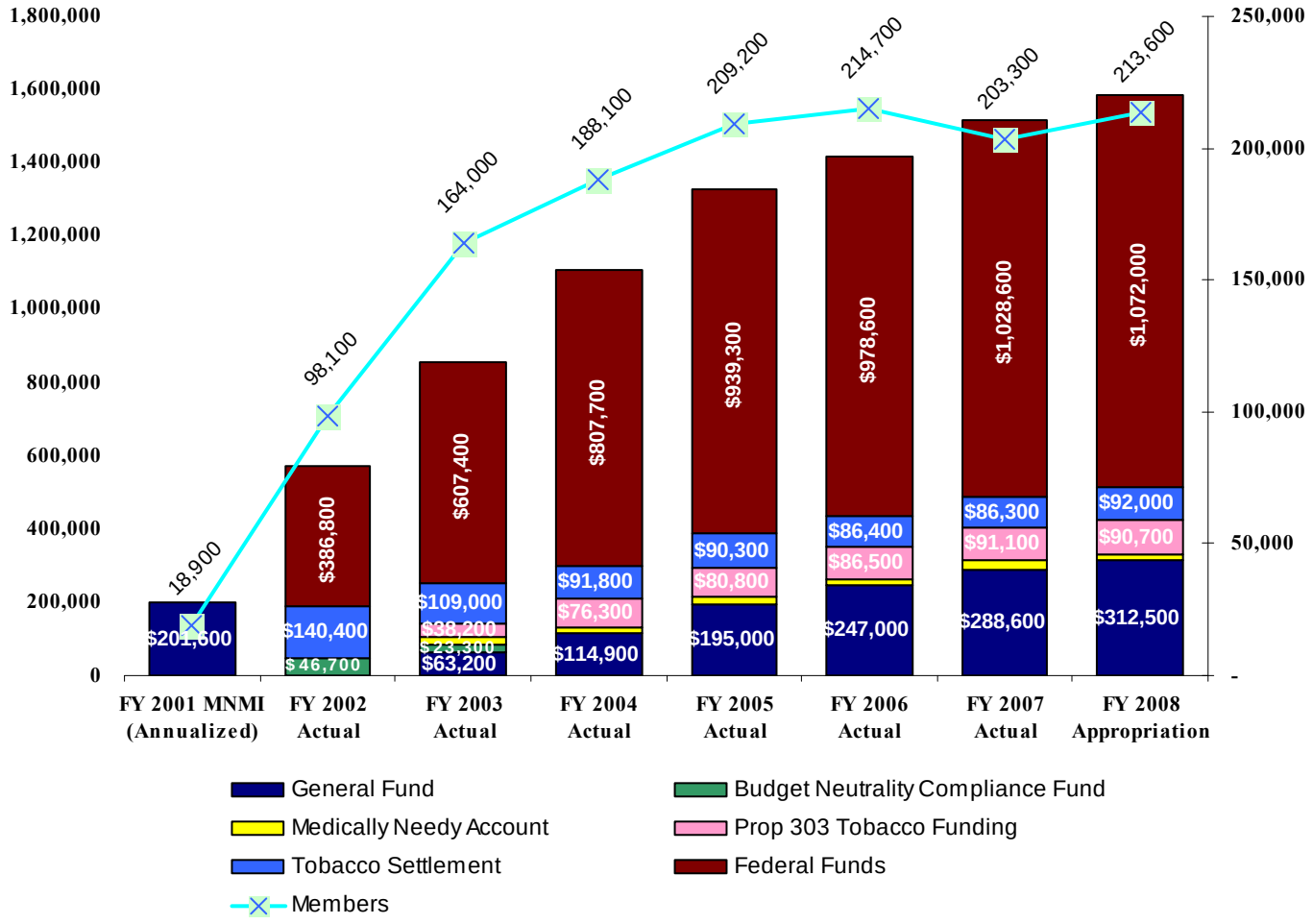
- Proposition 204: In late 2000, a voter initiative expanded Medicaid eligibility to 100% of the FPL. Prior to implementation of this proposition, most childless couples or single adults earning more than 35% of FPL did not qualify for AHCCCS. Many of these individuals were covered through county or state-only funds. Others received services for which the providers, such as hospitals and physicians, were not compensated. These types of unpaid costs are often passed on to consumers through cost shifting, where losses are balanced by higher premiums for commercial healthcare coverage and higher rates for healthcare services.

  As a result of the implementation of Proposition 204, a number of programs, supported solely by state and county funds, were eliminated. New Medicaid eligibility categories were created, replacing previous state and county funded programs such as those for the Medically Needy (MN) population which qualified for coverage based on catastrophic medical events. Although relatively small, these populations were very costly to the state.

  Implementation of Proposition 204 permitted Arizona to claim federal matching funds for populations previously covered by state and county funds only. New Medicaid categories for single adults and childless couples were created. As a result of these changes, Arizona has

been able to expand coverage to uninsured Arizona adults, without requiring a significantly greater portion of the general fund. It is important to recognize this benefit as budget constraints prompt the state to consider program cutbacks. If Proposition 204 had not been implemented—or if it is repealed—Arizona would still assume significant responsibility for this growing and costly population, albeit without the aid of federal Medicaid funds.

SFY 2001 MN/MI Expenditures vs. SFY 2002 - SFY 2008
Proposition 204
(Dollars in Thousands)



The figure above illustrates the number of individuals covered by the former MN/MI program and the state dollars required to fund this group in SFY 2001. For subsequent years, the figure illustrates how additional funding sources, such as tobacco settlement and tobacco tax revenues, as well as federal Medicaid funds, have been leveraged to cover a larger population (213,600 in SFY 2008 versus 18,900 in SFY 2001).

- Employer Sponsored Insurance (ESI): As required by the Health Insurance Flexibility Act (HIFA) 1115 Waiver, Arizona is to develop and implement an Employer Sponsored Insurance (ESI) program. Arizona is to submit a plan to CMS for approval to subsidize

health insurance premiums for SCHIP-eligible populations with household incomes between 100% and 200% of FPL who have the option of receiving health insurance coverage through their employer. ESI allows for subsidized payments to be made on behalf of SCHIP-eligible individuals for their portion of their health care premium, with the expectation that their employers would pay a percentage of the premiums for individual and family coverage.

In September 2007, however, AHCCCS requested new guidance from CMS related to the development of an ESI program. This request is the result of the uncertainties that have been generated as a result of the current SCHIP reauthorization debate.

- In other states, where similar programs have been implemented, families indicate that they prefer to receive coverage through their employer's insurer to avoid the stigma of public coverage. The advantage of this type of arrangement is that a significant portion of Arizona's Medicaid matching funds will be paid by the employer rather than through SCHIP funds. Arizona must obtain state legislative authority as well as implement and provide services through an ESI program by October 1, 2008 or experience the elimination of Title XXI expenditure authority and funds for health populations eligible for the health insurance for Parents program.

The HIFA Parents Program
Decreases the number of uninsured in Arizona.
Decreases the state cost in general funds for some populations.
Increases program savings by sharing healthcare coverage costs with employers.

In the course of Congressional debate regarding reauthorization of SCHIP, serious consideration is being given to terminating authority to use Title XXI funds for adults, including parents of eligible children. At the time of this writing, the debate appears to be deciding whether to terminate funding effective for one additional year or to permit all waivers to expire with no possibility of renewal. Arizona's waiver will expire September 30, 2011. Under President Bush's proposal, Arizona may be required to terminate SCHIP eligibility for these parents as soon as September 30, 2009.

It is important to note that continued renewal by the Arizona Legislature of the AHCCCS HIFA program is necessary for the implementation of an ESI program. Renewal of the HIFA Parents program is also important in that it provides premium-based coverage for the working parents of KidsCare or Medicaid-enrolled children at a higher federal matching rate. Further, it offers insurance to a population that typically cannot afford coverage or does not have coverage available through an employer.

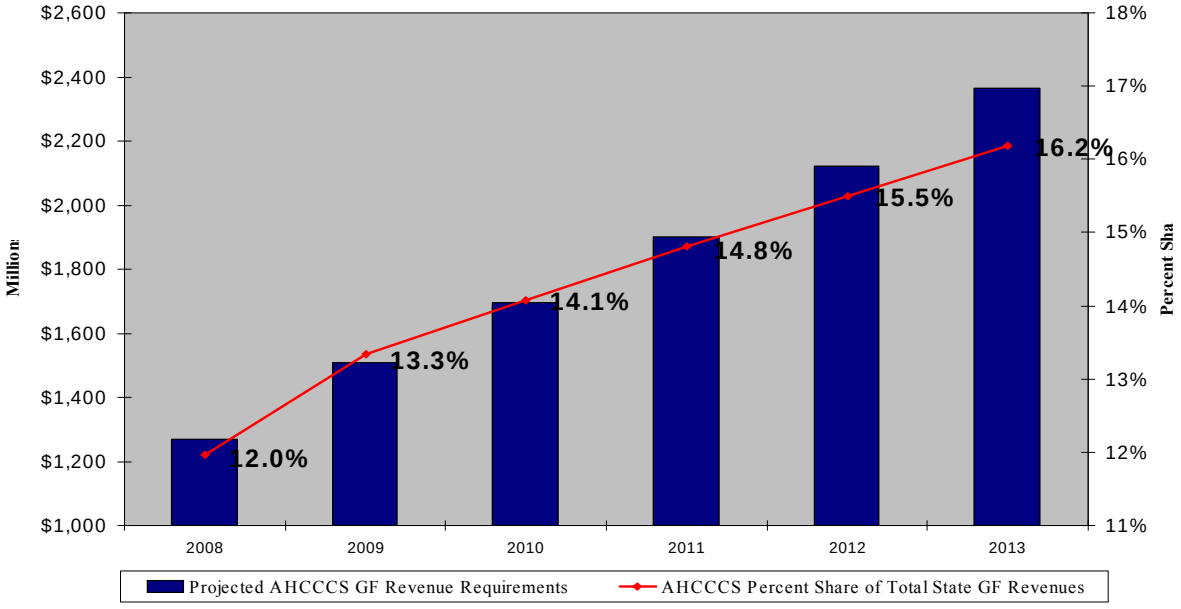
Significance to AHCCCS

As enrollment growth and health care costs continue to increase, AHCCCS expenditures are expected to consume an increasing portion of the state General Fund. The AHCCCS allocation of the General Fund is estimated at 14.2% for SFY 2008 (see chart below), and is projected to increase to 15.0% for SFY 2009.

Naturally, future allocations are dependent upon continued strong tax revenues and federal funding. The following figure shows potential growth of state General Fund revenues, and illustrates AHCCCS' projected revenue requirements for SFY 2008-2013. It is expected that AHCCCS will experience continued enrollment growth and require a greater percentage of state General Fund revenues. Thus, it is imperative that AHCCCS continue to focus on cost control strategies that can effectively manage this growth. This is particularly important because future demands on the state General Fund will be compounded by several factors:

- Reductions in Federal Fiscal Relief: Since 2004, when Congress did not extend the federal fiscal relief that was provided to states to meet budget shortfalls, General Funds have been compensating for the consistent annual decreases in federal funding.
- Decreased employer-based health care coverage: Continued pressure by diminishing employer-based coverage and increasing low-wage employment increases the need for Medicaid services.

Estimated AHCCCS General Fund Requirements and Percent Share of Total State General Fund Dollars



Note: Projected General Fund revenues are based on a ten-year average of annual increases

By controlling the growth in expenditures, AHCCCS can help conserve state funds for other critical state services such as education and public safety. An ongoing challenge for AHCCCS will be to develop cost control strategies that (1) will not ultimately end up increasing costs (e.g., restricting the number of prescriptions per month can lead to increased hospitalizations), or (2) will not interfere with efforts to reduce the number of uninsured. (See Appendix for Total Resources and Assumptions.)

Accomplishments in the Past Year

- Rate Restructuring: In support of a manageable, equitable, and predictable payment structure, AHCCCS continued to review and adjust reimbursement rates. Appropriate rates ensure continued participation of valued providers.

- Membership Management: AHCCCS is committed to controlling unnecessary program expenditures by implementing strategies to ensure members are enrolled in the most appropriate AHCCCS programs. In SFY 2007, AHCCCS continued to work with Arizona Department of Economic Security (ADES) to identify the key barriers to accuracy, develop and implement training for staff, monitor progress, and propose best practices for implementation statewide.

- Native American Health Initiative (NAHI): The agency continued the NAHI, a collaborative effort with Indian Health Services (IHS) and the tribes. The goal of NAHI is to maximize the 100% federal pass-through reimbursement to IHS and 638 tribes, thereby enabling IHS and the tribes to expand their facilities and services for Native Americans.

STRATEGIC ISSUE #1:
Health Care Costs

GOAL: Maintain average annual capitation rate (per member per month) increases at or below 6%.

AHCCCS STRATEGIES:

- Continue efforts toward more equitable and manageable provider rate structures and payment methodologies.
- Maintain membership management practices that ensure members are enrolled in the most appropriate AHCCCS programs.
- Continue to explore cost-effective purchasing options for key Medicaid services.
- Maximize use of non-state funding sources (e.g., grants).
- Establish and monitor health plan quality and cost benchmarks to ensure efficient cost-effective health plan operations.
- Continue to work with CMS to implement Congressional Budget Reconciliation bills and support Medicaid legislative changes to reduce program costs.
- Use Executive Utilization Management reports for ongoing health plan comparison and benchmarking.

PERFORMANCE MEASURES:

- Average percent change in capitation rates (overall per member per month)
- Eligibility error rates
- Percent of AHCCCS funding attributable to non-state funding sources
- Cost savings/cost avoidance from implemented strategies

RESOURCE ASSUMPTIONS:

Dollars are shown in thousands:

Strategic Issue # 1	SFY09	SFY10	SFY11	SFY12	SFY13
FTE	33	-	-	-	-
General Funds	12,897,500	-	-	-	-
Other Appropriated Funds	-	-	-	-	-
Non-Appropriated Funds	-	-	-	-	-
Federal Funds	47,920,400	-	-	-	-
Total Funds	**$60,817,900**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) Assumptions are either critical issues or decision packages within the agency's SFY09 Budget Submittal.
2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
To facilitate successful implementation of the Strategic Plan, the following resources are included in the SFY 2009 Budget Request:

Reinstatement of the HIFA Parent Program – The HIFA Parent program is scheduled for repeal at the end of SFY 2008. AHCCCS estimates that over 14,000 parents will lose their healthcare coverage if this program is not reinstated. Additionally, the state will not maximize the agency's federal SCHIP dollars. Funding requested for the continuation of this program is $59,007,200 Total Fund ($12,170,000 General Fund).

Caseload Growth – AHCCCS is requesting 31 FTEs and $1,693,200 Total Fund ($699,800 General Fund) in order to manage caseload growth in the Acute Care, ALTCS, and SCHIP Programs. Due to continual program growth, AHCCCS cannot achieve cost savings in the future without additional resources. Critical oversight functions are at risk, including coding and rate specialists that control claim costs, contract managers that ensure the provision of appropriate services, and IT positions that handle systems responsible for accurate payment and data analysis. The lack of these critical functions can be costly to the state if not funded.

Another key element responsible for the savings realized by these three programs in recent years has been the agency's ability to take prompt action to deny or discontinue program services to ineligible members. Timely and accurate application processing is particularly important because minimal increases in membership can lead to significant increases in cost. Due to continual program growth, AHCCCS cannot achieve cost savings in the future without additional resources.

Premium Billing – The KidsCare and HIFA Parent programs have been consistently growing over the last several years. In SFYs 2006 and 2007, the KidsCare and HIFA Parent enrollment increased by 15.9% and 6.0%, respectively, with no new administrative resources. As these programs are projected to continue to increase in double digits over the next two fiscal years, AHCCCS is requesting 2 FTEs and $117,500 Total Fund ($27,700 General Fund) to maintain adequate billing efforts.

STRATEGIC ISSUE #2:
Health Care Quality and Access to Care

Quality health care is multi-faceted, encompassing a vast array of criteria that result in receiving the correct treatment in the right setting at the right time. It blends both the science of health care and the personal aspects of receiving care in a culturally-respectful manner by ensuring that care is tailored to meet the needs of individuals. Quality health care includes both disease management and the prevention of illness, and results in fewer medical complications, better outcomes, and lower costs. Access and availability are key factors in ensuring the delivery of quality health care. Inability to access care may result in delayed treatment and treatment in inappropriate settings, leading to poorer health outcomes and increased costs. Quality health care, and access and availability to care, are addressed separately in the following text. However, it is important to keep in mind that access to care is a key component of delivering quality health care; therefore, the two issues are not mutually exclusive.

"Quality driven health care results in fewer medical complications, better outcomes, and lower costs."

A. Quality Health Care

Environmental Scan

Health Status

Following are key health status characteristics of specific populations within the United States, Arizona, and the Medicaid population. The 2006 United Health Foundation's composition index of states ranked Arizona 34th in the nation in terms of its overall health status, considering both risk factors (e.g., violent crime and lack of health insurance) and health outcome measures (e.g., mortality and disease prevalence). This ranking has clearly eroded, as evidenced by the 2005 ranking of 31st and the 2004 ranking of 23rd in the nation. Although improvements have been made and are encouraging, the state continues to face a number of challenges. In general, the Medicaid population tends to have poorer health status than the non-Medicaid population. As a result, some of the statistics presented below may be even higher when applied to Arizona's Medicaid population. In addition, given Arizona's culturally diverse population, it is important to note that ethnic disparities exist within each of these key populations.

Children

The Annie E. Casey Foundation's *2007 Kids Count Data Book* ranked Arizona 36th in the overall well-being of its children. This ranking was based on factors such as mortality, family composition, adequacy of income, and educational attainment.

Births:

- According to the National Center for Health Statistics, the latest data available (Preliminary 2005) shows Arizona has a higher rate of births than the national average (16.2 per 1,000 births compared to 14.0 per 1,000 births nationally), and is ranked 3rd in the nation (behind Utah and Texas), with AHCCCS covering 52% of the births. Arizona's birthrate among teens is also one of the highest nationally.
- Although declining, Arizona's teen (ages 15-19) birth rate is higher than the national average (60.1 per 1,000 births compared to 41.1 per 1,000 births nationally). Arizona ranks 6th nationally in this regard.
- The rate of low and very low birth weight and pre-term infants tends to be significantly higher among blacks in Arizona and nationally.

Chronic Illness:

- Asthma is a serious chronic disease that affects the lives of over 20 million Americans, 600,000 (3%) of whom are Arizonans. Consistent with the nation-wide average, 8% of Arizona children currently suffer from asthma.
- The National Health and Nutrition Examination Survey is a standardized survey instrument that has been used, since the mid 1960s, to measure overweight among children. The most recent survey indicates that an estimated 17% of children and adolescents ages 2-19 years are overweight. Moreover, it shows that overweight increased from 7.2% to 13.9% among 2-5 year olds, from 11% to 19% among 6-11 year olds, and from 11%-17% among adolescents ages 12-19. Children who are overweight are at an increased risk of developing type two diabetes, cardiovascular problems, orthopedic abnormalities, arthritis, and skin problems.
- Pediatricians are disturbed by the rapidly increasing trend of Type II diabetes in children. Previously, this form of diabetes was associated specifically with older adults.
- The most prevalent chronic childhood disease is dental caries (tooth decay). Dental caries is an infectious disease that is particularly widespread among the indigent and minorities. It is five times more common than asthma and it is estimated that 80% of the disease occurs in 20% of the population. Typically, the populations with the highest incidence of this largely preventable disease are low-income and minority children.

Adults

Chronic Illness:

- Chronic conditions are the leading cause of death and disability nationwide, affecting over 45% of the population (including 117 million adults). They are responsible for over two-thirds of all deaths and account for approximately 78% of health care spending. In fact, between 2000 and 2030, the number of Americans with chronic conditions is expected to increase by 37%. It is disturbing, therefore, that, although chronic conditions are the most prevalent and costly of all health problems, they are also the most preventable.
- Consistent with nationwide statistics, chronic disease accounts for seven of the 10 leading causes of death in the state of Arizona (Arizona Health Status & Vital Statistics, 2004).

- A snapshot of those with chronic conditions reveals that: (1) Chronic conditions affect women disproportionately - 80% of women aged 65 to 85 report at least one chronic condition compared to 33% of men in that age group; (2) Half of all people with chronic conditions have multiple chronic conditions; (3) Among people over 65, hypertension is the most common chronic condition; and (4) Among those 18 to 64, chronic mental conditions are the most common.
- Diabetes is expected to place a significant burden on Arizona's health care delivery systems in the next decade. As reported in the most recent *Diabetes in Arizona Status Report (November 2005)* 6.6% of the adult population has been diagnosed with diabetes. Hospitalization rates related to the disease are rising, and the average hospital stay for an individual with diabetes costs over $26,000. Certain populations such as Native Americans and Hispanics have higher incidences of Type II diabetes than the general population. According to vital statistics, the overall statewide ratio of deaths from diabetes in 2005 was approximately 20.1 per 100,000 population. The ratio for Arizona Native Americans was 69.9 per 100,000 population (an increase from 55.8 per 100,000 in 2003).
- According to a 2007 report published by the Arizona Department of Health Services and based on the ongoing Arizona Behavioral Risk Factor Surveillance System survey as well as the hospital discharge database and mortality data, the prevalence of obesity rate in 2006 was 22.9%. This means that, over the past 15 years, the estimated prevalence of obesity in Arizona's adult population more than doubled.
- On a more positive note, heart disease rates in Arizona have been decreasing.

Men's Health:

- A leading cause of death among men is heart disease, followed by cancer. Fortunately, the risks associated with both can be reduced with changes in lifestyle.
- Lung cancer is the most common type of cancer responsible for male deaths. Ninety percent of lung cancers result from smoking cigarettes.
- Approximately one in six men in the United States will be diagnosed with prostate cancer during their lifetime. In Arizona, prostate cancer is the most commonly diagnosed cancer and the 3rd leading cause of death in men. A total of 3,400 new cases and 520 deaths from this disease are estimated for 2007.

Women's Health:

- In Arizona, the percentage of pregnant women receiving prenatal care in the first trimester has increased slightly over the past several years to 78%. Despite the increase, however, this rate remains lower than the national average of 84%.
- Women are more likely than men to have chronic conditions. In part, this is because women typically live longer than men.
- The percent of women reporting poor mental health is higher than that of men.
- The American Cancer Society estimated that 3,220 new cases of breast cancer will be diagnosed among women in Arizona in 2007, with disproportionately higher rates among the black population.

Health Status Concerns and Economic Impact

Consequences of the Lack of Quality Care

Increased Costs: Lack of quality care leads to additional hospitalizations and increased health care costs. Nationally, quality problems are thought to account for up to 81,000 preventable deaths a year and billions of dollars in avoidable hospital costs and lost productivity. Research, conducted by the National Committee for Quality Assurance (NCQA), demonstrated that the lack of care for four common conditions (asthma, depression, diabetes, and hypertension) accounted for an annual loss of 64.7 million working days in productivity, costing an approximate $10.6 billion.

Reduced Quality of Life: Individuals living with chronic conditions are challenged physically, emotionally, and financially. The public's three greatest fears related to chronic conditions are: (1) Inability to pay for care, (2) Loss of independence, and (3) Becoming a burden to family and friends.

Factors Contributing to Poor Health Status

A major concern is that obesity is often the precursor to diseases such as diabetes, coronary heart disease, arthritis, or stroke. To the extent that lifestyle choices factor into the development of chronic disease, wellness programs to reduce smoking, decrease substance abuse, and control weight through diet and exercise can reduce future costs related to the chronic care burden.

Aging: As the percentage of Arizonans over the age of 65 increases, there will be more individuals with disabilities and multiple chronic conditions requiring long term care. This fact is of particular concern given current findings indicating that individuals enrolled in the long term care program account for only 4% of the AHCCCS population but 27% of AHCCCS expenditures.

Factors for Consideration in Strategy Development

Coordination of Care: Nearly half of all people with chronic conditions have multiple chronic conditions and three or more different physicians. Coordinating care for individuals with multiple chronic conditions can be challenging, particularly given the added complexities of the Medicare Modernization Act (MMA) and its related drug benefit programs. Often times, people with multiple chronic conditions report receiving inadequate information from their providers. Others may fail to receive information about potentially incompatible drugs. Still others may undergo duplicate tests or procedures. Coordination between disciplines is a vital ingredient of quality care. Coordination failures can be both costly and dangerous.

Ethnic Disparities: Cultural competence and consideration of ethnic disparities impact quality of care, particularly in Arizona, with its diverse population. In particular, language barriers may cause difficulties in communicating important information and instructions to patients, increasing the risk of error. The latest survey of AHCCCS members indicated that between 12% and 14% of respondents had some problems communicating with their medical provider.

Approximately 8% reported needing an interpreter. Studies show that communication is a key factor in the development of trust. Further, when patients trust their medical providers, compliance improves.

Improving Quality of Care

Prevention and Wellness

Prevention and wellness services are among the most cost-effective. These services include immunizations, prenatal care, wellness programs, health education, and age-appropriate health screenings and immunizations. Although these programs are established for prevention, they also allow for early identification and treatment of disease.

Medical Management

Disease Management/Chronic Care Models: Disease management programs employ stratified interventions based on patient health status and risk. Often, disease management programs focus on patients with high risk and/or chronic conditions that have the potential to benefit from concerted intervention (e.g., diabetes, asthma, cardiovascular disease, HIV/AIDS). Chronic care program models assist individuals in managing their own care. In general, disease management programs are associated with more effective practice patterns, improved quality of care, and lower costs.

Diabetes serves as a good example of the potential value of disease management. As an example, a study published in the Annals of Internal Medicine, found that health care providers' use of management programs resulted in higher rates among their patients of recommended examination, such as eye and foot exams, testing for kidney function or damage resulting from diabetes, cholesterol checks, and getting vaccinations.

Case Management and Care Coordination: Case management applies to individuals with catastrophic, chronic, or multiple conditions that consume a disproportionate share of an organization's health care dollars. It typically includes individualized patient education, care coordination, and assistance with navigation through the health care system. Although case management efforts are often part of an organization's disease management program, they may also be extended to control high utilizers and difficult-to-manage individuals who are not in dedicated disease management programs.

Evidence-Based Treatment Guidelines and Best Practices

Basing medical management decisions on evidence-based treatment guidelines and best practices is an effective means of managing costs and improving quality. Specific practice guidelines that identify treatment protocols for various conditions can reduce treatment disparities and improve outcomes. These protocols have been developed with both outcomes and cost efficiency in mind. Effective practice guidelines, commonly used in disease management programs, may lead to reduced inpatient and emergency room utilization and changes in patient care patterns.

Oral Health

Dental services are categorized by CMS as an optional Medicaid benefit for adults. Arizona provides comprehensive dental services for AHCCCS-enrolled children but historically has limited adult benefits to emergency dental services. Because oral health is intricately tied to general health, limiting dental benefits does not necessarily result in cost savings. Many diseases and poor health outcomes are related to the presence of oral disease. Some of the associated conditions include diabetes, coronary artery disease, preterm low birth weight, and complications in patients with cancer, organ and tissue transplants, and other conditions resulting in immunosuppression. Thus, strategies for the delivery of oral health services are important considerations, particularly as they relate to the expansion of adult coverage.

Centers of Excellence

Centers of excellence focus on particular disease episodes related to high-cost, high-volume conditions. They consist of a network of hospitals, physicians and other providers who integrate care to achieve both quality outcomes and cost efficiencies. Physicians and facilities having obtained a degree of excellence in their areas of expertise may be certified through such national organizations as the American Academy of surgeons. Examples of centers of excellence include those dedicated to cardiac care, diabetes management, organ and tissue transplantation, burns, and cancer treatment.

Pay-for-Performance and Provider Recognition Programs

One of the four cornerstones of the Value Driven Healthcare System promoted by CMS is the use of incentives aimed at improving delivery of appropriate care and avoiding costly errors. Provider performance programs vary from national government-sponsored efforts to health plan-specific initiatives. Currently, multiple health plans offer pay-for-performance (P4P) compensation to physicians nationwide. This number is expected to increase significantly. P4P programs have met with varying degrees of acceptance by physicians and other providers, depending greatly on both the methodology of the P4P program and the perceived aims of those programs.

AHCCCS has worked with the provider community to develop a P4P program that meets with provider acceptance and promotes improvements in the health care delivery. This program will initially address improvements in the care of members with diabetes and an increase in the number of two-year olds receiving all recommended vaccinations.

In addition, a P4P program for nursing home providers is also under consideration. This program would provide an additional lump sum payment to the top 40% of nursing facilities that have the lowest incidence of preventable pressure ulcers on their residents. Legislative approval is necessary before either P4P program can be initiated.

Enhanced Member Education and Cultural Sensitivity

Studies show that knowledgeable and informed managed care members have greater compliance and healthier behaviors. Strategies to enhance member education may include activities such as the use of multi-language videos to explain the managed care system as well as how to establish

routine care through a primary care physician, access qualified interpreters to communicate medical information, and appropriately use an emergency department. The effective use of telecommunications and internet technology can improve patient communication and understanding of the importance of prevention and lifestyle changes, ultimately resulting in reduced costs.

Member and Provider Satisfaction

Research indicates that satisfaction of both members and providers is an important factor in an effective managed care delivery system. Provider dissatisfaction has been linked to poor clinical judgment, disruption in continuity of care, and patient dissatisfaction. Failure to address such issues may lead to a loss of quality physicians, the need to increase rates to the remaining network, and access to care issues. Member dissatisfaction may be linked to such behaviors as "no-shows," non-compliance with treatment, and alternative use of emergency departments. Failure to address such issues may lead to inadequate care and, ultimately, higher costs. Conducting both member and provider satisfaction surveys, and using the findings to inform quality improvement activities is an important step toward ensuring ongoing quality of care.

Significance to AHCCCS

It is critical that AHCCCS members receive quality services from AHCCCS health plans. Maintaining a high level of quality facilitates the effective use of state and federal dollars, and may ultimately lead to a healthier and more productive Arizona population. To ensure that they are providing quality services to members, AHCCCS health plans are required to report on a selection of performance measures that are part of the Health Plan Employer Data and Information Set (HEDIS) established by the National Committee for Quality Assurance (NCQA). HEDIS is now the most widely used methodology for measuring preventive and other health care services, having been adapted and adopted by Medicaid, Medicare, and commercial health plans nationwide. In addition, AHCCCS uses a variety of internal performance measures to gauge the quality of services provided to members.

B. Access to Care

Environmental Scan

Availability and Accessibility of Providers

Number and Distribution of Physicians

Arizona's rapid population growth is placing significant pressure on the current health care infrastructure and its health care facilities, making it more difficult for the state to accommodate the needs of a growing population. The state is facing shortages of both professional staff as well as hospital beds. Recent reports indicate that the ratio of Arizona physicians to population increased 6% from 207 per 100,000 in 2004 to 219 per 100,000 in 2005. Despite this increase, Arizona remains well below the nationwide ratio of 246 per 100,000. The ratio of hospital beds in Arizona is 2.0 per 1,000 people vs. a ratio nationwide of 2.9 per 1,000 people. Furthermore, the distribution of providers in urban versus rural areas is disproportionately in favor of the urban areas.

A variety of barriers and concerns interfere with the recruitment and retention of providers in Arizona:

- Rising malpractice costs
- Extended work hours due to limited networks and shortages of providers
- A high rate of uninsured individuals
- Reductions in provider reimbursement

Based on survey results, the Harris Management Group concluded that the issues of greatest concern to Maricopa County Physicians were:

- Reimbursement
- Malpractice Insurance Costs
- Operating Expenses
- Regulation

Additional data collected from respondents indicated that:

- 25% reported a decrease in time spent with each patient
- 40% reported a decrease in income
- 62% reported less enjoyment from practicing medicine
- 50% believed that the cost of malpractice insurance adversely impacted access to care and overall quality

Geographical Concerns

A total of 5,716 areas in the United States were designated as Health Professional Shortage Areas (HPSA) as of June 30, 2007. Of these, 67% are in non-metropolitan areas.

Health Professional Shortage Areas (HPSA) in Arizona

		Primary Care	Dental	Mental Health
US standard for population-to-practitioner ratios		2,000:1	3,000:1	10,000:1
Estimated Unserved Population in Arizona		832,487	492,267	916,021
Number of practitioners needed to:	Remove HPSA Designation	244	110	59
	Achieve US standard for population-to-practitioner ratios	391	144	84

Source: HRSA Information Center, Shortage Designation Branch; Health Professional Shortage Areas, Tables 2-5, dated as of June 30, 2007.

Further, the U.S. Health Resources and Services Administration (HRSA) defines Medically Underserved Areas/Populations (MUA/MUP) as a whole county or a group of contiguous counties, a group of county or civil divisions or a group of urban census tracts in which residents have a shortage of personal health services; and MUPs may include groups of persons who face economic, cultural or linguistic barriers to health care. Arizona is home to a number of these areas. According to HRSA, 44 areas in Arizona currently have federal MUA/MUP designations. Generally, these are rural areas. Persons living in these designated areas:

- Are more likely to be uninsured than urban residents.
- Generally tend to be poorer and less healthy than those in urban areas.
- Have more difficulty obtaining necessary health care services because the number of providers is limited, as is availability.
- Have difficulty obtaining transportation to receive necessary care. Specifically, necessary specialty care may require extensive travel.
- Have fewer choices for health insurance coverage because the HMO penetration rate in rural areas is lower than in urban areas. In addition, employer-sponsored insurance is less widely available in rural areas due to the proliferation of small businesses that are less likely to offer employee health insurance.

Additional Factors for Consideration in Strategy Development

Coverage Options and Choice of Providers in Rural Areas: Health plans (both HMOs and PPOs) may avoid rural areas because of a lack of providers as well as consumers. When they do decide to offer coverage in rural areas, network development can prove difficult, particularly in view of Arizona's current shortage of medical professionals and hospital beds. The lack of competition in these areas may also drive up health care costs.

Inappropriate Use of Emergency Rooms: When provider networks are inadequate and/or residents are uninsured, emergency departments provide a costly alternative to primary care.

Transportation Services: The provision of medically-necessary transportation (including EMS) is an ongoing challenge that affects cost as well as accessibility to care.

Lack of Care and Delayed Care: It is generally accepted that a lack of access to care or lack of timely access to care may be linked to poor health outcomes. Approximately 46% of insured and 57% of uninsured individuals with chronic conditions report problems accessing care. Individuals with serious chronic conditions also report difficulty accessing specialty services.

Ethnic Disparities: The Commonwealth Fund reports that "Hispanics are more likely than any other group in the U.S. to be uninsured and have difficulty obtaining access to health care – this problem is made worse by language barriers." These concerns are significant for Arizona and AHCCCS, both with substantial Hispanic populations.

Strain on Providers: Because Arizona has a lower provider/population ratio than the national average, Arizona providers work harder to fulfill the demand for health care. Many report working longer hours, receiving less reimbursement, and compromising quality of life.

Approaches to Improving Access to Care

Safety Net Providers

Safety net providers, such as Community Health Centers, are an important source of care for Medicaid beneficiaries and for the uninsured. In Arizona, 75% of all community health center patients are either uninsured or enrolled in AHCCCS. Approximately 35 non-profit, community-based primary care organizations across the state account for over 140 service sites (including clinics, satellites, and school-based programs).

Improving Availability of Care

Development of alternative locations for non-emergency care and extended hours can be an important approach to ensuring that members do not seek care in more costly inappropriate settings. Development efforts may be in collaboration with a variety of stakeholders (e.g., community health centers).

Telemedicine

Telemedicine programs offer valuable opportunities for improved accessibility to health care in both rural and metropolitan communities. The Arizona Telemedicine Program provides telemedicine services throughout much of Arizona, including 57 hospital/clinic sites, 59 behavioral health sites, 25 correctional facility sites, 5 school sites, and 8 health sciences education and research sites. In addition, AHCCCS supports the Community Health Center/Office of Rural Health Collaboration to expand telemedicine services and develop payment policies that stimulate their use.

Graduate Medical Education (GME)

GME includes required internships, residencies, and fellowships a physician must complete following graduation from medical school as part of the physician licensing process. Following payments by patients and Medicare, Medicaid is the next largest explicit payer of GME, estimated at nearly $3.2 billion nationally in 2005, comprising about 7% of total Medicaid inpatient hospital expenditures. States are not obligated to pay for GME, but it has long been recognized that Medicaid funding is critical to ensuring that there are physicians available to treat Medicaid patients in a hospital setting. As a result, Medicaid programs in 47 states and the District of Columbia make explicit payments to teaching hospitals to subsidize GME costs.

There is no explicit authority for Medicaid funds to pay for direct GME costs (resident salaries, faculty stipends, and program administrative costs); however, state Medicaid GME payments have been matched by the federal government at each state's usual Medicaid matching rate since Medicaid's beginnings. Payments for indirect GME costs (increased hospital operating costs resulting from teaching activities) are expressly authorized.

In his Fiscal Year 2008 budget proposal, President Bush proposed to end federal Medicaid funding for direct GME costs, estimating savings to be $140 million in FY2008 and $1.780 billion from FY2008-FY2012. This move would not affect payments for indirect GME costs. In May 2007, the Centers for Medicare and Medicaid Services published proposed rules implementing the President's proposal. Congress placed a one-year moratorium on the implementation of the proposed rules to give the subject time for further study.

Researchers at the Arizona State University and the University of Arizona found that Arizona employs 20.7 physicians per 10,000 people, which is already substantially below the national average of 28.3 per 10,000 people. If Medicaid GME funds are eliminated, it is expected that Arizona's ability to attract and sustain medical residency positions would quickly deteriorate.

Since the site of residency training is a major influence on a physician's choice of a location to practice, graduate medical education programs offer the potential to improve recruitment and retention of providers throughout the state. AHCCCS currently supports more than 100 GME programs training more than 1,260 residents in Arizona with annual payments to hospitals totaling more than $33 million for the direct costs of resident training.

Other Provider Recruitment and Retention Programs

Besides graduate medical education, a variety of incentives have the potential to improve recruitment and retention of providers in rural areas. They include:

- National loan repayment programs
- The J-1 visa waiver program for foreign physicians
- Community health center opportunities and support
- Educational opportunities and supervised practice experience for medical and dental students
- Residency programs
- Equitable compensation that takes regional costs into consideration

Significance to AHCCCS and Arizona

AHCCCS recognizes the importance of adequate access to health care services for all Arizonans as an effective means of maximizing prevention efforts and controlling health care costs. Its future expenditure forecast is built on the assumption that members will have access to services that are available within reasonable proximities to their homes. In addition to their impact on the quality of health care, availability and accessibility to care ultimately impact local economies. Hospitals, medical groups, community clinics, and private practice providers all serve as positive economic generators for communities around the state.

Accomplishments in the Past Year

- Graduate Medical Education: In FY2007, payments to hospitals for direct GME costs included $12 million of new funding for new and expanded GME programs. AHCCCS also began offering interest-free loans to hospitals for the start-up costs of new GME programs, especially in rural areas. To date, AHCCCS has been able to offer loans to three hospitals that are expanding GME opportunities by establishing new programs. In addition, AHCCCS developed and codified a methodology for indirect GME funding, with first payments scheduled for June 2008.
- Pediatric Development Tool: Based on recommendations of the School Readiness Board Health Implementation Team, and in collaboration with the Arizona Academy of Pediatrics, AHCCCS developed and implemented an assessment program for children at risk for developmental delays. Infants admitted to the Newborn Intensive Care Unit at birth are screened using the Parent Evaluation Developmental Screening (PEDS) tool. Physicians who are trained to use this tool are reimbursed by AHCCCS for the screening. As a result of this early evaluation, selected infants are referred for additional assessments and services related to individual developmental needs, improving the likelihood of positive outcomes.
- Childhood Obesity: AHCCCS implemented a childhood obesity program in Pima County at two Federally Qualified Health Care Centers and one hospital system. Criteria for enrollment and treatment are based on medical guidelines developed by AHCCCS and approved by various medical associations in Arizona. Careful data collection and analyses will facilitate outcomes reporting in future years.
- Performance Measure Improvements: AHCCCS completed its annual report of performance measures related to access to care and children's preventive health services received by members enrolled with acute-care contractors. Rate increases were noted in a number of categories including: 1) 45-64 year old access to preventive and ambulatory health services; 2) well-child visits in the first 15 months of life; 3) annual dental visits by Medicaid and KidsCare members. In addition to rates published in the report, AHCCCS measured services to screen for cancer and Chlamydia among women, as well as initiation of prenatal care. Increases were noted in cervical cancer screening, Chlamydia screening, and timely initiation of prenatal care. Measurements of services received by ALTCS members with diabetes also showed improvement in the areas of hemoglobin A1c testing and lipid screening.

- Performance Improvement Projects: A number of Performance Improvement Projects (PIPs) currently underway place intensive efforts on improving specific areas of need. Under a PIP to improve children's oral health, the combined rate (Medicaid and KidsCare) of annual dental visits among children ages three through eight, a critical time to prevent tooth decay, has improved by more that 10 percentage points since the baseline measurement was conducted four years ago. Another PIP, focusing on increased physician reporting of vaccinations to the state immunization registry, which is intended to improve immunization completion rates among children and adolescents, has shown significant improvement in the first two years of the project.
- Oral Health Policy: In 2007 the Arizona legislature approved funding for an adult dental benefit under the ALTCS Program. With the understanding that oral health is the number one unmet health care need among this senior population, the Governor approved a budget that included this new benefit. Currently all adults enrolled in AHCCCS receive emergency dental services and medically necessary dentures. Beginning October 1, 2007, the new ALTCS benefit will allow each adult member to receive an additional $1,000.00 annually for preventive and therapeutic services in addition to those currently allowed.
- Children's Oral Health Performance Improvement Project (PIP): For the measurement period ending September 30, 2006, the overall rates of annual dental visits for both Medicaid and KidsCare populations increased over the previous year. The rates are well above the national Medicaid mean.
- CHCS Pay-for-Performance Development Grant: AHCCCS was one of six state Medicaid programs awarded a technical assistance grant by the Center for Health Care Strategies (CHCS) to develop a pay-for-performance program. In addition, CHCS selected AHCCCS to participate in a program to develop a Return on Investment (ROI) calculator designed to evaluate P4P programs and the expected fiscal impact on state Medicaid programs. CHCS intends to provide the ROI calculator to other states after it is developed, which is anticipated to be in early 2008.
- Learning Network for Quality Purchasing: AHCCCS was selected by AHRQ as a lead state to participate in a learning network on quality purchasing. The primary benefit of participation is assistance with development of a P4P program. This two year learning network completed its work during 2007 and AHRQ will issue a final report based on the efforts of all participants.

STRATEGIC ISSUE #2:
Health Care Quality and Access to Care

GOAL: Improve quality and access to care.

AHCCCS STRATEGIES:

- Improve incentives to promote health plan quality outcomes.
- Promote evidence-based treatment guidelines and best practices.
- Continue to investigate opportunities to use designated Centers of Excellence for members with high-cost and complex diseases to improve both quality of care and cost-effectiveness.
- Develop additional measures to monitor quality outcomes for long-term care recipients.
- Conduct a satisfaction survey of long-term care members.
- Explore the concept of a medical home for children with special needs as a means of facilitating coordination of care and streamlining the transition to adult services.
- Develop a web-based information exchange (IE) system that allows providers access to diagnosis, treatment, and other information that supports coordination of care.
- Improve members' understanding of how to access needed medical care.
- Begin making incentive payments of up to $9 million to hospitals for indirect GME costs, contingent on the hospital's creation of resident rotations in rural areas of the state.
- Design a system-wide Pay-for-Performance program targeted at improving health care services provided to select populations. (Current targets include members with diabetes, vaccinations for two-year olds, and nursing facility residents.)
- Improve children's oral health by promoting the establishment of a dental home by age one.
- Provide basic oral health services to all adult members.
- Prepare for the needs of a growing ethnically diverse population by promoting cultural competence throughout the health care delivery system.
- Evaluate the networks of contracted health plans to determine their adequacy in meeting the needs of members.

PERFORMANCE MEASURES:

- Member and Provider satisfaction as it relates to quality of care
- Additional quality and utilization measures appropriate for benchmarking
- HEDIS measures and HEDIS access to care indicators
- Emergency department utilization
- Number and percent of provider types by geographical area by plan
- Number and percent of telemedicine encounters
- Number and percent of provider encounters
- Provider/Member ratios
- Member satisfaction as it relates to accessibility of care

RESOURCE ASSUMPTIONS:

Dollars are shown in thousands:

Strategic Issue # 2	SFY09	SFY10	SFY11	SFY12	SFY13
FTE	10	-	-	-	-
General Funds	4,053,600	-	-	-	-
Other Appropriated Funds	552,700	-	-	-	-
Non-Appropriated Funds	44,800	-	-	-	-
Federal Funds	8,267,600	-	-	-	-
Total Funds	**$12,918,700**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) Assumptions are either critical issues or decision packages within the agency's SFY09 Budget Submittal.
2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
To facilitate successful implementation of the Strategic Plan, the following resources are included in the SFY 2009 Budget Request:

Performance Pay – AHCCCS is requesting 3 FTEs and $8,053,800 Total Fund ($2,238,000 General Fund) to fund Pay-for-Performance (P4P) programs in SFY09. This fund will be used to incentivize contracted Acute Care health plans to achieve higher levels of performance.

Graduate Medical Education (GME) – One of the major contributing factors to the increases in health care costs in recent years is the shortage of qualified medical professionals in the state. An adequate pool of physicians and medical professionals in Arizona is imperative for providing quality healthcare services to its residents. AHCCCS is requesting $1,346,800 Total Fund ($504,400 General Fund) to support the GME program, which provides teaching hospitals with additional funding to compensate for the high operating costs associated with the teaching programs.

Medical Management – AHCCCS has faced large increases in its population since 2001 and implemented several new program initiatives and changes with little or no additional administrative resources. AHCCCS is requesting 7 FTEs and $745,800 Total Fund ($358,200 General Fund) to address critical medical management that will allow AHCCCS to continue its success of managing health care costs while increasing the quality of care provided to Arizonans through positive program outcomes.

Indian Advisory Council – Tribes in Arizona exhibit health disparities when compared to the general population of the state and the nation. In order to meet strategic objectives that will improve the healthcare outcomes for tribal members, the Indian Advisory Council requested $107,100 Total Fund ($53,400 General Fund) to provide the additional resources necessary to accomplish these tasks.

Board of Nursing – The Arizona Board of Nursing, which oversees the licensing and regulation of the Certified Nursing Assistant program, has been repeatedly under-funded. AHCCCS is requesting $234,400 Total Fund ($117,200 General Fund) for SFY 2009 in order to fund operational shortfalls and critical investigative positions for the Board that are needed for timely investigations of potentially unsafe practitioners. Through these investigations, the risk to the health and welfare of the public is reduced, resulting in greater quality of care for Arizonans.

Smoking Cessation Program – An Arizona Adult Tobacco Survey conducted in 2005 identified that nearly one in five adult residents currently use tobacco (a 19% prevalence rate). Research has shown that the use of first-line Nicotine Replacement Therapies (NRT) (i.e., gum, patches, lozenges, and Varenicline/Chantix) can double or even triple patients' chances of successfully quitting tobacco.[1] AHCCCS proposed to add NRT as a covered service under Arizona's Medicaid program in an effort to create a healthier population, resulting in overall lower health care costs. The agency is requesting $2,430,800 Total Fund ($822,700 General Fund) to fund this program.

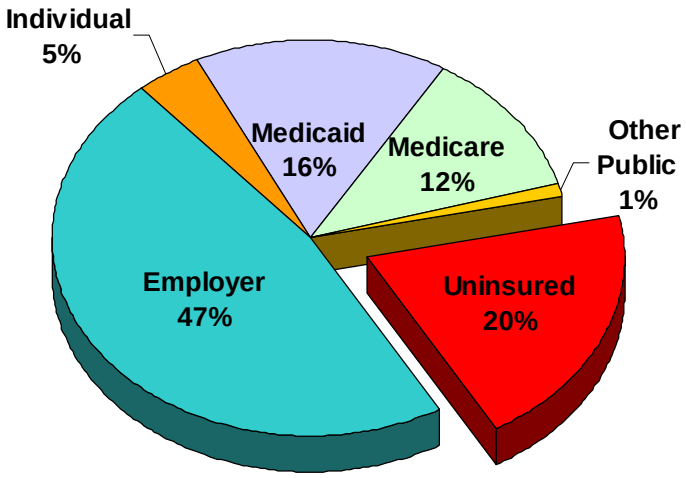
[1] Fiore, et al. Clinical Practice Guideline: Treating Tobacco Use and Dependence. Rockville, MD: U.S. Department of Health and Human Services' Public Health Service. June 2000.

STRATEGIC ISSUE #3: The Uninsured

D*espite ongoing efforts to address the issue, Arizona's 20% rate of uninsured (2005-06) is growing and continues to be among the highest, when compared with 16% nationwide. Over 1.2 million Arizonans are without health insurance, ranking Arizona the 9th highest state in the nation for total uninsured, and the 4th highest for uninsured as a percentage of total population. Percentage-wise, Arizona trails Texas, New Mexico, and Florida. A slowly recovering economy, declining employer-sponsored insurance (ESI), and increasing medical costs and health care premiums, remain important factors contributing to the growth in the uninsured. Lack of insurance has serious health and financial consequences, affecting not only the uninsured individual, but the health care delivery system and the Arizona economy as well.*

"20% of Arizonans lack health insurance."

Arizonan's Coverage Status



Environmental Scan

National Growth of the Uninsured

In September 2007, the Lewin Group released findings of an analysis of the uninsured, commissioned by Families USA. The Census Bureau's Current Population Survey and the Survey of Income and Program Participation were used to compare changes in the number of people under the age of 65 who were uninsured for some or all of the two-year periods between 1999-2000 and 2006-2007. Results show that 89.6 million people, or more than one out of every three non-elderly Americans, were uninsured in the 2006-2007 period. This also represents an increase of 17 million uninsured Americans since the 1999-2000 period. Further, of those who went without health insurance for some or all of 2006-2007, 64% were uninsured for six months or more. Lewin reports that, "Increases in health insurance premiums, a changing labor market, and under-funded health care safety net programs have all contributed to the growth in the number of uninsured Americans during this period."

The national uninsured rate has steadily risen to nearly 47 million in 2006. Of the increase in uninsured children from 2005 to 2006, 48% was among families with incomes between 200%

and 399% of the federal poverty level. Reversing years of steady declines, the number of uninsured children has grown by one million over the last two years, including 700,000 in the last year alone. In total, nearly 80% of all uninsured are U.S. citizens; and, between 2004 and 2006, 76% of the growth in the uninsured was among citizens.

Who are the Uninsured in Arizona?

Numerous key characteristics of the uninsured in Arizona and many contributing factors help to explain the lack of coverage:

- Income and Costs of Insurance: It is estimated that 70% of uninsured Arizonans (ages 0–64) in 2006 resided in family households with incomes below 200% of the FPL, though 37% of this age group lived in poverty (Kaiser). Among non-elderly adults, ages 19-64, the uninsured accounted for 49% of those living in poverty. Persons in poverty are defined as those making less than 100% of FPL. In 2006, 100% of FPL was $9,800 for a single person and $16,600 for a family of three; 200% FPL was $19,600 for a single person and $33,200 for a family of three. Lower income ranges such as these make the purchase of private health insurance coverage nearly impossible.

  In their 2007 Employer Health Benefits Summary of Findings, Kaiser and Health Research Education Trust report that, even workers who had employer-sponsored insurance between Spring 2006 and 2007, still paid an average of $3,281 toward their share of family coverage premiums—twice as much as they paid in 2000. Total annual premiums for employer-sponsored coverage averaged $4,479 for single coverage and $12,106 for family coverage. Those without employee-sponsored insurance can expect to pay more for premiums due to an inability to negotiate group rates, and will also foot the entire cost of premiums. In short, high costs preclude low-income persons from obtaining health insurance, assuming insurers are agreeable to sell them a policy at all.

  On a related note, Kaiser analyses suggest that Health Savings Accounts and high deductible health plans are no more affordable for low-income families than existing plans, and the high deductibles may shift even more health care costs onto them.

  According to a national study published in the *Journal of the American Medical Association* (December 2006), 48.8 million respondents younger than age 65 lived in households that spent more than 10% of their annual income on health care in 2003, compared with 11.7 million in 1996; about 18.7 million spent more than 20% in 2003. The study estimated that 17.1 million respondents had inadequate financial protection from high out-of-pocket health expenditures, including 6.6 million with public coverage. These costs are associated with delaying or forgoing medical care, behavior that can have severe consequences for those in poor health.

  A nationally representative survey of 1,201 adults ages 18 years and older, was conducted by *ABC News*, the Kaiser Family Foundation, and *USA Today* in September 2006. Of those respondents who were uninsured, 66% stated that they had been uninsured for two years or more, demonstrating that this issue can generally be thought of as one that is long-term. Furthermore, 54% stated that they didn't have insurance because it was too expensive,

followed by 15% who didn't because they were refused the option to purchase it due to poor health, illness, or age.

- Age and Gender: Approximately 31% of all young adults ages 19 to 24 (especially males) are uninsured, and are more likely to be uninsured than any other age group. Many young adults place a low priority on health insurance and are unwilling to seek coverage they view as unnecessary. The rate of all uninsured adults in Arizona, ages 19-64, is 25% as compared with 20% nationally.

  The rate of uninsured Arizona children 0 to 18 is 17%, comparing with 12% nationally, due to a greater proportion of children qualifying for public programs with expanded eligibility criteria (e.g., KidsCare). Nevertheless, national estimates indicate that significant numbers of uninsured children who are not enrolled in Medicaid or KidsCare are indeed eligible. This may be because families are either unaware of the opportunities or are unable to navigate through the enrollment process.

- Race/Ethnicity: In Arizona, Hispanics account for 32% of the population as a whole, but for 57% (704,000) of the total sub-population of non-elderly uninsured, an increase of 114,000 in the past year. Whites account for 30% (376,000) of the uninsured, a decrease of 11,000 in the last year. Hispanics also account for 48% of all AHCCCS members and 60% of all KidsCare members.

- Citizen Status: Of the 6,166,300 persons identified as Arizonans in 2006 Census estimates, 89% are citizens and 11% (655,400) are non-citizens. Arizona is third in the nation for the highest population distribution of non-citizen residents. New Jersey is comprised of 12% non-citizens; and, at 16%, California leads the nation. Non-citizens do not qualify for Medicaid assistance, and so many do not obtain needed healthcare at all, which ultimately leads to higher death rates and incidences of poor health as compared with those who are insured. However, when the uninsured do address healthcare needs, it is often through more costly emergency services routes, or through health safety net clinics.

- Geographic Location: Rural residents account for 13% of Arizona's population, are more likely to be uninsured than urban residents, and are less likely to have access to employer-based insurance. Rural areas generally have higher unemployment rates and a higher percentage of households with low median family incomes. Arizona rural areas also experience a 30% poverty rate as compared with 19% in metropolitan areas. These factors all contribute to a lack of insurance.

- Employment Status: Contrary to common perception, the majority of uninsured individuals are employed. In fact, 72% of the uninsured have at least one full-time worker in the family unit, and an additional 9% have a part-time worker in the family unit. Although these family units are linked to the workplace through the employee, employer-based health care coverage may not be offered, may not be affordable, or may have eligibility restrictions.

  According to Kaiser's Employer Health Benefits 2007 Annual Survey, the overall rate of private-sector employers in Arizona offering health insurance declined from 69% in 2000 to 61% in 2007, primarily due to decreases in small firms (3-199 workers) offering coverage. The smallest firms (3-9 employees) are less likely to offer insurance than are larger firms of 50 or more (45% compared to 95% comparatively). Additional facts offered by the AHRQ show that Arizona has suffered along with the nation in a drop in health insurance offerings.

From 2000 to 2005, the percent of businesses offering health insurance dropped from 63% to 55%. This drop is primarily due to small businesses with fewer than 50 employees, where health insurance offerings dropped from 50% to 38%, while larger firms essentially stayed stable with 97% offering. In addition, 46% of all employees work in retail and other service industries, only 55% of which offer health insurance.

- Reduction in Employer-Sponsored Coverage: Health insurance premiums continue to demonstrate disproportionate increases. Kaiser reports that, in 2007, premiums increased 6.1%, significantly more than the 3.7% gain in wages and 2.6% gain in inflation. Since 2001, family healthcare coverage premiums have increased 78%, while increases in wages and inflation have risen only 19% and 17%, respectively.

Economic Impact

The uninsured have poorer health status and lower life expectancy. They receive fewer preventive and diagnostic services, often postpone care because of costs, tend to be more severely ill when diagnosed, and generally seek care in hospital emergency rooms or at safety net clinics.

The uninsured impact both the economy and the health care delivery system in Arizona. This evidenced by:

How the Uninsured Affect the Economy:
Cost Shifting Due to Uncompensated Care
Increased Government Spending
Greater Financial Stress on Providers
Lower Earnings and Educational Attainment

Cost Shifting Due to Uncompensated Care
The Arizona Hospital and Healthcare Association estimates that only 7% of the state's hospital payments come from the uninsured. Charity care and bad debt assumed by Arizona's hospitals in 2005 accounted for a total of $249 million in healthcare services for which hospitals were not reimbursed. These costs must be passed on to other healthcare consumers in the form of higher insurance premiums.

Increased Government Spending: Health care services for the uninsured, which are primarily supported by federal, state, and local governments, account for approximately $35 billion (85%) of the uncompensated care bill. As the number of uninsured increases, the demand for publicly supported services increases, requiring additional allocations of public funds. According to the Institute of Medicine, the United States loses an estimated $65 billion to $130 billion every year as a result of poor health and premature deaths related to the lack of health insurance. This estimate includes lost productivity, lost value of life, and the increased economic costs of illness and death.

"The United States loses an estimated $65 billion to $130 billion every year as a result of poor health and premature deaths related to the lack of health insurance"

Financial Stress on Providers: The uninsured place financial stress on providers, especially private physicians for whom uncompensated care is not subsidized by government dollars. In order to make up for uncompensated care costs, providers may increase their rates. Ultimately

these increases are reflected in the premiums that are paid by those who have insurance. Not only do the uninsured drive up costs, but they also affect provider accessibility by leading to changes in provider practice patterns (e.g., refusal to be on-call in emergency rooms).

Reduction in Earnings and Education: Lack of health insurance impacts more than physical well being. Because a lack of insurance coverage compromises health status, adults may experience reduced earning power or other employment problems. Children may exhibit poor school attendance, lower achievement, and even arrested cognitive development, all of which compromise educational opportunities.

Additional Concerns

Without significant economic improvement and health care cost control, a number of other factors have the potential to aggravate the current situation and cause an increase in the number of uninsured:

Employees Opting Not to Enroll in Coverage: Instead of opting to drop coverage altogether, many employers are scaling back coverage and shifting more of the financial burden to their employees. Employees are faced both with higher monthly premium contributions and greater cost-sharing requirements (i.e., higher deductibles, coinsurance, and co-payments). As a result, employees, especially low-wage earners, may opt to forgo employer-based coverage.

Decline in Retiree Coverage: Individuals who retire before they are eligible for Medicare benefits typically depend on employer-provided retiree health programs for coverage. However, the cost of providing these types of benefits has increased, causing employers to reconsider coverage offerings to retirees. Results of a Kaiser/Hewitt survey released in December 2006 reported that 74% of large employers in 2006 increased premiums for retirees under age 65, 58% raised premiums for Medicare-eligible retirees, 34% raised cost-sharing requirements for under-65 retirees, and 24% did so for Medicare-eligible retirees. Between 2005 and 2006, 11% of surveyed employers eliminated benefits for a group of future early retirees and 9% did the same for a group of future Medicare-eligible retirees. Looking to 2007, 10% of firms say they are very or somewhat likely to eliminate subsidized coverage for some future retirees. The survey also indicated that these trends will accelerate, including the raising of drug co-payments and out-of-pocket costs.

Elimination of Parents with Title XIX/XXI Children: Arizona received a Health Insurance Flexibility and Accountability (HIFA) 1115 waiver to help expand coverage to parents of SCHIP and Medicaid children. Continuation of the Health Insurance for Parents Program (also known as HIFA Parents) is dependent upon annual legislative approval and continuation of federal authority to operate the program. Elimination of this program could leave roughly 14,000 premium-paying members without health care coverage. This is disconcerting, particularly since studies show that, in many cases, participation of children in health maintenance programs is frequently higher when their families also have coverage. In addition, a majority of these parents are not offered or cannot afford employer-sponsored insurance. Termination of this optional coverage group because of a lack of funding would also mean that AHCCCS could not implement a proposed employer-sponsored insurance pilot.

State Approaches to Address the Uninsured

Over the past decade, many states, including Arizona, have expanded government-sponsored health care programs or increased support to direct care programs in order to address the issue of the uninsured. States have also tackled this issue by intensifying outreach efforts and simplifying enrollment procedures for these programs. Despite state budget shortfalls and rapidly increasing health care spending, states are finding ways to continue to expand coverage to the uninsured. States have actively explored opportunities to improve access to private health insurance including options such as: taxpayer and business subsidies to cover insurance costs for people who cannot afford it; sliding-scale premiums and, in some states, premium assistance; health insurance purchasing pools; safety net "bare bone" health insurance policies; and more.

Significance to AHCCCS

In keeping with its mission, AHCCCS is the principle provider of health insurance to low-income Arizonans, many of whom do not have access to affordable private sector health insurance. Over the past 20 years, Arizona has successfully reduced the state's uninsured rate through voter-approved major program expansion initiatives, such as the HIFA waiver (1997), KidsCare (1998), and Proposition 204 (1999). In addition, Healthcare Group, a public/private partnership administered by the AHCCCS Administration, began in 1996 and was designed to offer affordable health coverage to small businesses with 50 or fewer employees. Currently, approximately 17% of Arizonans receive coverage through the combination of these AHCCCS programs, a percentage that has nearly doubled since 1998. (This percentage is based on 2007 AHCCCS enrollment numbers in comparison with the 2006—the latest available—annual population estimates for Arizona from the Census Bureau.)

The uninsured have serious health and financial consequences that affect the state as a whole and AHCCCS in particular. As the number of uninsured increases, the demand for AHCCCS coverage increases. It is also important to keep in mind that the uninsured have a significant impact, both directly and indirectly, on AHCCCS' rising health care costs. Upon enrollment, their health status is often poor, a factor that adds to the cost of care and directly impacts AHCCCS costs. In addition, the burden created by the uninsured impacts the viability of the health care delivery system for all consumers, including AHCCCS members, and indirectly affects AHCCCS costs.

Accomplishments in the Past Year

- Health-e-Arizona: AHCCCS is in the process of transferring Health-e-Arizona (HEA) from El Rio Health Center to AHCCCS. HEA is a web-based, eligibility screening and application referral system, enabling Arizonans to apply electronically for health and social service programs with assistance from trained application assistors. Community organizations work in partnership with AHCCCS, the Arizona Department of Economic Security, and community programs to provide a one-stop application process. Application assistors in

community organizations use HEA to help families apply and submit required documentation. Built on a user-friendly Microsoft platform, the application is available in both English and Spanish. HEA provides a "preliminary" eligibility determination and electronically routes the application to the appropriate state office(s) for formal processing.

Some Arizona communities have developed discount medical networks to serve those who do not qualify for AHCCCS programs. If the organization using HEA is part of the provider network of a Community Access Program (CAP), HEA also screens the applicant for CAP eligibility. If the applicant qualifies and chooses to enroll, the application assistor can collect the CAP enrollment fee and enroll the applicant in the discount program. In addition, HEA calculates the family's percentage of the Federal Poverty Level to enable community clinics to immediately enroll applicants into their own sliding-fee scale programs and determine the family's payment.

Using HEA, subscriber organizations guarantee that applications and required documents are submitted to the state, receive contact information for the state worker processing the application, continue to work with the family to encourage a positive outcome, and receive the state's final determination. State agencies benefit by receiving legible, edited data, fully completed applications, required documentation, fewer interviews and faster feedback to application assistors and applicants.

STRATEGIC ISSUE #3:
The Uninsured

GOAL: Reduce the rate of uninsured Arizonans by providing reasonably-priced health care coverage options.

AHCCCS STRATEGIES:

- Educate the public about available programs for the uninsured and offer enrollment assistance to potentially eligible families; in doing so, collaborate with community-based organizations, faith-based organizations, schools, and school districts to conduct KidsCare outreach and informational activities.
- Implement, as part of the HIFA waiver, an employer-sponsored insurance option to assist eligible KidsCare families with coverage through small employers.
- Evaluate other coverage options under the HIFA waiver as well as other types of strategies for maximizing the impact Medicaid and SCHIP programs have on reducing the rate of uninsured.
- Refer applicants who are ineligible for AHCCCS to alternative resources for insurance coverage and medical care.

PERFORMANCE MEASURES:

- Number and percent of uninsured adults and children in Arizona
- Number and percent of adults and children participating in AHCCCS programs
- Number and percent of employers offering health insurance to Americans and Arizonans

RESOURCE ASSUMPTIONS:

Dollars are shown in thousands:

Strategic Issue # 3	SFY09	SFY10	SFY11	SFY12	SFY13
FTE	-	-	-	-	-
General Funds	423,600	-	-	-	-
Other Appropriated Funds	-	-	-	-	-
Non-Appropriated Funds	2,860,900	-	-	-	-
Federal Funds	3,155,100	-	-	-	-
Total Funds	**$6,439,600**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) Assumptions are either critical issues or decision packages within the agency's SFY09 Budget Submittal.
2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
To facilitate successful implementation of the Strategic Plan, the following resources are included in the SFY 2009 Budget Request:

Children's Health Insurance Program – In an effort to address the high number of uninsured children in Arizona, as well as increasing associated costs, AHCCCS requires an additional $480,000 Total Fund ($113,700 General Fund) to fund outreach efforts. Keeping children healthy, prepares them to learn and positions them contribute to Arizona's economic future.

Healthcare Group – AHCCCS administers the Healthcare Group program that provides medical coverage to small businesses with 1–50 employees that would otherwise remain uninsured. The agency is requesting an additional $2,860,900 from the non-appropriated Healthcare Group Fund for SFY 2009 programmatic service costs. A lack of funding for this program would result in a higher number of uninsured Arizonans utilizing more costly forms of care (i.e., emergency departments), due to the unavailability of primary care services.

Family Planning Expansion – Family planning services provide individuals with the information and means necessary to exercise personal choice in determining the number and spacing of their children. AHCCCS is requesting $3,098,700 Total Fund ($309,900 General Fund) to allow non-pregnant women between 100% and 150% FPL to receive these services. This is in addition to the current program allowing enrollment only for women who already gave birth to a child on AHCCCS.

STRATEGIC ISSUE #4:

Organizational Capacity

***S**uccess of the AHCCCS Strategic Plan is dependent upon a strong and effective infrastructure that can support the agency's work and respond to a dynamic health care environment. Organizational capacity encompasses both the human and technology elements necessary to service stakeholders. In order to further develop such a structure, the agency must focus on two critical areas:*

A. *Information Technology*
B. *Workforce Planning*

Enhancing organizational capacity is critical as agencies are asked to expand services, improve cost control, reduce turnover and serve ever growing populations on relatively small administrative budgets. Organizational capacity is influenced by both the technology available to an agency and the needs of its customers. Maximizing organizational capacity allows the agency to be more effective. In the following sections, we will address how focusing on this issue, will help the agency to achieve its long term goals.

A. Information Technology

***O**rganizations today are dependent on sophisticated information technology systems. The ongoing challenge is maintaining information technology systems that encompass the most current state-of-the-art technologies as well as meet constantly changing demands and needs of the organization. Each year, federal and state policy makers strive to meet the challenges of an increasingly complex Medicaid program, while maintaining goals of improved health outcomes and efficient administration. Ongoing enhancements to information technology systems within AHCCCS are imperative if the agency is to achieve the program goals set forth in this strategic plan.*

"Ongoing enhancements to information technology systems within AHCCCS are imperative if the agency is to achieve the program goals set forth in this strategic plan."

Environmental Scan

National Trends

Government Accessibility

One-stop, online access to information and services is needed for citizens, businesses, and governments. According to President George W. Bush, "Implementation of e-government is important in making government more responsive and cost effective." In response to the need for online services expansion, AHCCCS built a robust web interface with its customers and other agencies and continues to enhance web capabilities.

A self-service portal is now in the planning stages. Once operational, this portal will allow the public to apply for healthcare benefits, renew current eligibility, report changes, check enrollment and eligibility status, and find answers to questions related to programs, services, and eligibility without intervention of staff and at any time of day. Other functions include ordering replacement AHCCCS ID cards, reporting address changes, requesting health plan changes, requesting voluntary withdrawal from the program, reviewing claims and paying premiums, and the use of geospatial mapping to assist in locating services. In addition, for those who do not currently use the Internet, an eligibility IVR is planned that will, via telephone, allow AHCCCS members to report changes and initiate renewals, and allow applicants to initiate their applications for AHCCCS programs.

AHCCCS is also developing e-Learning modules which can be easily disseminated to its employees, whether they work at an office or home location.

Accommodating Medicaid Changes and MITA

The Medicaid program has constantly evolved in response to federal and state regulations and mandates, changes in demographics, innovations in health sciences and information technology, and increases in coverage, services, variety of delivery models, and costs. Each year, federal and state policy makers have struggled to meet the challenges of an increasingly more complex Medicaid program, while maintaining its goals of improved health outcomes and efficient administration.

The information technology systems supporting the state Medicaid programs have evolved to meet the individual policies, needs and budgets of each state. Frequently, these systems are unable to share data easily across programs, constraining the availability of information to decision makers such as health care providers, administrators, and policy-makers. Resources shortages, increasingly complex eligibility and payment rules, and the requirement for rapid response to federal and state mandates and court orders are a few of the day-to-day challenges that states must currently meet, while utilizing IT systems that do not respond easily to change.

To meet the changing needs of the Medicaid community, such as improved health outcomes, application of performance measurements, and data sharing, states must capture the

comprehensive data needed to analyze health outcomes, track resource investments with intended results, and employ mechanisms to share administrative and clinical information across states and multiple programs. Unfortunately, states are limited in their resources to transition their programs, as well as introduce innovation into their IT capital planning and investment process. These problems make it more difficult than ever for states to plan and acquire the technology and processes needed to support and improve their Medicaid programs. Many states have had to outsource their systems in order to more efficiently keep up with all of the changes and control costs.

The Medicaid Information Technology Architecture (MITA) is an initiative of the Center for Medicare and Medicaid Services (CMS) to establish national guidelines for technologies and processes that enable improved program administration for the Medicaid enterprise. It includes an architecture framework, a business process model, a capability maturity model, and planning guidelines for enabling state Medicaid enterprises to meet common objectives within the MITA framework while supporting unique local needs.

MITA is a new approach to the federal-state partnership to build and support state Medicaid information systems, promote data sharing, and create an environment of interoperable systems that adapt to the challenges of the Medicaid Program. The overall goal of the MITA project is to facilitate an improved process for design and implementation of systems that improve the quality and efficiency of health care delivery, which in turn will improve beneficiary and population outcomes.

MITA has a business process focus. That is, technology capabilities should support the business, rather than drive it. The MITA architecture model will reflect not only state-level operations and program interactions, but also the interactions between federal and state Medicaid components through the utilization of industry standards, increased use of off-the-shelf software, and utilization of secure storage and transmission of data. This model will exhibit a common "look and feel" to users, use a common set of federal reporting requirements, and will allow the independent use of specific software or hardware.

The MITA mission is to provide quality health care to members by providing access to timely and cost-effective services; to improve health care outcomes for Medicaid beneficiaries; and to ensure efficient, effective, and economical management of the Medicaid program. Specific MITA goals are to establish a national framework of enabling technologies and processes that support improved program administration for the Medicaid enterprise and stakeholders; to develop seamless and integrated systems that effectively communicate, achieving common Medicaid goals through interoperability and standards; and to promote an environment that supports flexibility, adaptability, and rapid response to changes in programs and technology.

Aging System

AHCCCS' legacy system, the Prepaid Medical Management Information System (PMMIS), is 16 years old and operates on an older technology. It is becoming increasingly more difficult to implement the necessary changes as required by our nationally recognized health care program. The database and programming languages are currently supported, but no major improvements are planned in the near future. There are limited trained resources, most being trained in-house.

With two states to consider (i.e., Arizona and Hawaii), it is necessary to develop an overall strategy for the future that addresses the expected life of the system (or individual components), the direction of the market as a whole, statewide enterprise architecture, service-oriented architecture, e-Health, MITA, and federal and state regulations.

Preliminary estimates range from 18 months to five years to replace our system. Given this time frame, it is important that this project get underway before the PMMIS can no longer meet AHCCCS' needs.

Value Driven Health Care and HIeHR Utility

As already stated within the "Value Driven Health Care" section of the Introduction to this plan, AHCCCS is currently making significant progress towards formalizing Value Driven Health Care. AHCCCS was awarded $11.8 million under a federal Medicaid transformation grant from the Centers for Medicare and Medicaid Services (CMS) in February 2007 to create a statewide, web-based secure Health Information Exchange utility and Electronic Health Record Utility (HIeHR utility). The secure web portal will give providers instant access to electronic health records where and when the information is needed for care. Additionally, a second grant totaling $4.4 million was awarded in November 2007 for development of a Value Driven Decision Support Tool Box.

Interoperable Health Information

The HIeHR utility will address the first cornerstone of interoperable health information systems. Interconnectivity allows for better exchange of clinical data, resulting in more accurate diagnoses and appropriate care. In addition, the availability of data will reduce redundant laboratory and radiology procedures, resulting in a decrease in healthcare costs assumed by AHCCCS and by the entire healthcare system.

HIeHR Utility Project Phases

The HIeHR utility is being implemented in three phases:

- PHASE 1 (anticipated launch June 2008): focuses on the development and use of a statewide health information superhighway (the HIE) that includes the exchange and web-based display of four key types of health care information: h*ospital discharge summaries, medication history, laboratory test results,* and *advanced directives*. Significant progress has been made toward this launch including requirements gathering and analysis, design and development of the exchange, and record locator. Three hospital systems, two laboratory vendors, a pharmacy aggregating service and the Secretary of State's Advance Directive Registry have committed to participate in Phase I. Partner and Provider Adoption outreach efforts have also engaged nearly 100 professional organizations and provider groups. Local activities are complemented by national presentations and media.
- PHASE 2 (anticipated launch June 2009): will broaden the health information types and exchange participants and provide, through a secure web portal, key care applications including electronic prescribing, laboratory and radiology order entry, referrals, EPSDT

reports, and office visit notes. The concept development, planning, and requirements gathering for this phase is ongoing.

- PHASE 3 (anticipated launch December 2009): will make a spectrum of specialized applications, known as clinical decision support tools, available to providers, plans, and patients. These functions will help make getting the right care easy and efficient, and will enhance prevention, wellness, and illness programs across the continuum of care.

Business Continuity Preparations

Working with the Governor's Emergency Oversight Council, AHCCCS seeks to ensure the continued operation of its essential government functions during a wide range of potential emergencies and service disruptions. As part of its Continuity of Operations Planning, or Business Continuity Planning, the agency invests in ongoing staff training to be able to respond in the event of an emergency or adverse condition while maintaining communications, services, and operations capabilities.

Significance to AHCCCS

Technology is critical to more than just the reporting systems within the agency. Technology affects employees and customers by offering additional opportunities to enhance customer service and offering employees additional work option flexibility. AHCCCS is dependent on these systems in order to:

- Control health care costs, improve service delivery, and integrate program operations.
- Provide data reporting functions that support decision-making and strategic planning.
- Ensure effective communication with stakeholders (e.g., members, providers, and other stakeholders).
- Reduce turnover and training costs by offering options such as Virtual Office to employees.
- Enhance efficiency within and between agencies through the use of imaging and reduce the costs to store paper records.
- Provide enhanced web based services to health plans, members and providers while reducing the time employees spend responding to routine requests such as address updates.

B. Workforce Planning

Workforce planning is a critical and integral component of strategic planning. The right number of appropriately qualified workers must be available at the right time and in the right place if AHCCCS is to achieve its goals and accomplish its mission. With projected increases in both population and healthcare needs, AHCCCS can expect to see an increase in the demand for agency services. It can also expect to see heightened competition for vital talent at a time when its knowledgeable workforce is aging and retiring, Accordingly, it is faced with the challenge of attracting, developing, and retaining a workforce that is competent to address new objectives, new technology, and new operational requirements. Effective workforce planning allows for the building and shaping of a workforce prepared to meet strategic objectives.

"…workforce planning is a critical and integral component of strategic planning."

Environmental Scan

What is Workforce Planning?

Workforce planning is a systematic process for identifying the human resources required to meet agency goals, and developing the strategies to meet these requirements. According to the National Academy of Public Administration, an organization chartered by Congress to improve government at all levels, workforce planning involves:

- A systematic process that is integrated, methodical, and ongoing.
- Identification of the staffing needs required to meet agency goals; this involves determining the number and skills of needed workers and identifying where and when they will be necessary.
- Development of a plan to meet these requirements, which involves identifying actions necessary to attract and retain the number and types of workers the agency needs.

Establishing a Workforce Plan

A Workforce Plan is a living document that matures with the organization. The U.S. Department of Health and Human Services suggests that, in order to be effective, a workforce plan should incorporate:

- Supply Analysis: Identifying organizational competencies, analyzing staff demographics, and identifying employment trends.
- Demand Analysis: Analyzing future activities and workloads, and describing the competency set needed by the future workforce.
- Gap Analysis: Comparing findings from the supply and demand analyses to identify the gaps between current competencies and those needed in the future workforce.

- Solution Analysis: The process of developing strategies for closing gaps in competencies and reducing surplus competencies through strategies such as recruitment and training.
- Evaluation: A systematic review of the workforce plan to ensure that it remains consistent with the agency's mission.

AHCCCS is committed to the development and maintenance of a workforce plan that incorporates the general steps described above and addresses a number of key components including:

- Identification and Assessment of Core Competencies: Identifying and assessing department- or unit-specific competencies in relation to individual strengths and weaknesses, motivation, and personal values.
- Succession Planning: Identifying potential successors for key positions within the organization.
- Recruitment and Retention: Enhancing the effectiveness of hiring practices by using core competencies to structure the selection process and retaining employees longer through effective incentives and opportunities (i.e., salary packages, position progression, and Virtual Office opportunities).
- Performance Management: Aligning individual competencies with performance goals.
- Leadership, Employee, and Organizational Development: Using core competency gaps as a road map to guide employee training, and developing managers through ongoing education and promotional opportunities.

Key Issues

The building and maintenance of a competent workforce that supports Agency's goals is critical. Some key issues that impact and are impacted by the AHCCCS workforce include:

- Aging Workers: Aging of the workforce strains agency resources. Many individuals who have extensive knowledge of the agency's operations will be leaving after long tenures, taking their knowledge with them. As of November 2007, approximately 1,360 persons are employed at AHCCCS. Current analyses indicate that 39% of the agency's workforce will reach retirement age by the year 2020. Additionally, almost 7% of this number have already accumulated, or are within one year of accumulating, the total number of points (80) required for full state retirement benefits. For the next five years this rate will increase substantially, almost tripling in 2013, accelerating the loss of highly skilled employees, while simultaneously escalating costs to replace them. Retirement projections are: 7.0% (2008), 9.2% (2009), 12.5% (2010), 15.8% (2011), 19.6% (2012), and 23.6% (2013). These rates are further compounded by non-retirement separations.

- Absenteeism and Turnover: Similar to other state agencies, AHCCCS experiences higher rates of absenteeism and turnover than the private sector. The agency's turnover rate decreased to 16.5% in SFY 2008, due in large part to the success of Virtual Office.

- Budget Constraints: AHCCCS continues to expand its membership and its programs within the context of budget constraints that limit full-time positions and salaries, and challenge recruitment and retention efforts. Despite recent increases, state salaries remain at an estimated 7% below the market level.

- Changes in Technology: As technology replaces more of the mundane and routine work, a shift toward higher-skilled "knowledge worker" jobs is occurring. While this is a challenge to the agency in terms of recruitment, one of the benefits from new technology is that it also offers employees opportunities to work from alternate sites including their home and reduces the time spent on repetitive routine tasks, which can lead to employee burnout.

Significance to AHCCCS

Understanding these environmental realities and using them as a call to action, AHCCCS will be able to employ strategies to build and maintain an effective workforce. Focusing on developing leaders from within the agency will benefit AHCCCS and assist in employee retention efforts. Offering employees opportunities such as training and career development is likely to result in improved job satisfaction and a clearer understanding of and appreciation for their roles in overall AHCCCS operations. In addition, the opportunities afforded by Virtual Office and flexible work schedules have helped to attract and retain a more stable workforce.

Accomplishments in the Past Year

- Virtual Office Expansion: AHCCCS expanded its Virtual Office (VO) program. No longer a pilot program, VO opportunities exist in the Division of Fee for Service Management, the Information Services Division, the Division of Health Care Management, and the Division of Member Services.

  Since July 2005, AHCCCS has transitioned more than 300 employees, or 20% of the workforce, to full-time at-home employees. As a result of these efforts, AHCCCS ended its lease on two office buildings, including one in December 2007. Estimated annual savings from the first office closure is approximately $400,000 and from the second is $277,000. Additionally, minimum productivity increases range from 10% to over 45%.

  The advantages of working from remote telecommuting sites will continue to be assessed for further expansion. It is expected that in addition to high employee satisfaction and increased productivity, AHCCCS may be able to further reduce the number of offices needed statewide and, therefore, reduce overhead costs. In addition, it is expected that expansion of VO may enhance the candidate pool by allowing people with limited hours or mobility to join the workforce from home. Virtual Office also expands the worker pool to include rural locations that may be distant from AHCCCS worksites. For many of the lower level entry positions, the use of VO may help to reduce the turnover rate and attract a stable workforce by allowing more flexible work hours and reducing commuting costs. When termination ratios are compared, findings are dramatic: among VO staff, the termination ratio is 0.5 per 100 filled positions; among non-VO staff, the ratio is 1.5 per 100 filled positions. Thus, VO staff turnover is three times less frequent than non-VO staff turnover.

- Imaging System: An imaging system enables the electronic storage and retrieval of records previously available only in hardcopy. AHCCCS expanded its imaging capabilities throughout many areas of the agency, reducing costs associated with filing, storage, and retrieval of documents, and creating more efficient processes by streamlining the flow of work among multiple offices. It improves customer service by making documents available at other locations, while also enhancing document security.

- AHCCCS Website Enhancements (e-Government): A web-based tool entitled *MyAHCCCS.com* was implemented this year, enabling AHCCCS members to create an online account to securely access and manage eligibility and enrollment information. Features include English/Spanish options, viewing active and two-year history of healthcare eligibility and health plan enrollment, linking to active health plan websites and the annual enrollment change website, and more. The website will continue to be enhanced with new self-help features throughout the year, including plans for a web-based application to assist members applying for various AHCCCS programs.

  The availability of new online transactions was also added to benefit providers, health plans, other agencies, and internal staff. Additions include prior authorization request inquiry, birth record search, claims submission, National Provider Identification (NPI) number submission, health insurance survey, and a facilities management system. Eligibility verification inquiries by providers via the AHCCCS website frequently top one million per month. Benefits include avoided phone calls, allowing member services staff to address more complex issues. A newborn web function will be added in FY08 allowing health plans and hospitals to add newborn babies to the AHCCCS system without calling member services or waiting for online data to be updated later. Additionally, a few pilot e-learning modules were developed and implemented for field office and virtual office training.

- Public Assistance Reporting Information System (PARIS) Grant: This newly-implemented system allows AHCCCS and DES to maintain program integrity and detect and deter improper public assistance payments. Both agencies are now able to share demographic information with other states to increase accuracy in eligibility determinations for public assistance programs (i.e., TANF, Food Stamps, and Medicaid), thereby decreasing the potential for improper payments from state and federal tax dollars.

- Business Continuity: AHCCCS developed a new *e*-learning module that describes and augments how the agency will protect its staff, facilities, equipment, and records that support its essential functions. Additional drills and staff training in concert with the Department of Homeland Security and state agencies have allowed AHCCCS to further enhance its existing plan and capabilities.

STRATEGIC ISSUE #4:
Organizational Capacity

GOAL: Maximize agency capacity and resources and address workforce issues through the use of technology and planning.

AHCCCS STRATEGIES:

- Evaluate, acquire and install the next generation of AHCCCS software products and system architecture.
- Continue our partnership with Hawaii to share costs of developing and maintaining our Medical Management Information System and Data Warehouse.
- Implement National Provider Identification (NPI).
- Maximize the use of upgraded telecommunication capabilities.
- Design and implement expanded web-enabled capacity and capabilities, including the transformation of paper processes into electronic transactions/processes.
- Maximize the organization's ability to utilize data warehousing for reporting and decision-making.
- Continue to reduce the number of reports run against the Department of Administration's mainframe computer to reduce current data center costs incurred by AHCCCS.
- Continue to expand the Virtual Office environment to improve productivity and facilitate recruitment and retention of staff while decreasing infrastructure costs.
- Continue to address potential barriers/issues related to Virtual Office such as distance training/learning, recruitment from targeted populations, promotion issues and facility transition as offices are closed.
- Implement an employee development program.
- Implement recommendations from the Diversity Council.
- Continue to improve the hiring process to attract and retain a highly-competent workforce.

PERFORMANCE MEASURES:

- Customer satisfaction with IT functions
- Per unit transaction costs (i.e., eligibility, member services, and claims)
- DOA Data Center hours charged to AHCCCS
- Timeliness of hiring
- Individual and organizational performance objectives
- Employee satisfaction
- Employee grievances, complaints, and resolutions
- Number of eligible employees participating in Virtual Office
- Rate of employee turnover
- Rate of absenteeism

RESOURCE ASSUMPTIONS:

Dollars are shown in thousands:

Strategic Issue # 4	SFY09	SFY10	SFY11	SFY12	SFY13
FTE	18.6	-	-	-	-
General Funds	4,855,200	-	-	-	-
Other Appropriated Funds	-	-	-	-	-
Non-Appropriated Funds	-	-	-	-	-
Federal Funds	7,531,900	-	-	-	-
Total Funds	**$12,387,100**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) Assumptions are either critical issues or decision packages within the agency's SFY09 Budget Submittal.
2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Cost Assumptions:
To facilitate successful implementation of the Strategic Plan, the following resources are included in the SFY 2009 Budget Request:

Eligibility Technology Solutions – AHCCCS is requesting $1,863,700 Total Fund ($728,300 General Fund) to implement technology projects that will automate numerous application and eligibility functions. Expected improvement in the efficiency of eligibility administration includes: 1) Web-based Application for Public Use - a joint project between community health centers, AHCCCS, and DES utilizing a web-based application that facilitates enrollment of low-income children, adults, families and pregnant women in health care programs; 2) Geo-spatial mapping – A self-service system that locates service providers by zip code, thus reducing phone calls to AHCCCS and health plans; 3) Interactive Voice Response (IVR) – an automated phone system that will allow AHCCCS members to report changes and initiate applications and renewals by phone. Information will download directly into the eligibility computer system, reducing the time required to key new information into that system; 4) E-find - a computer application that expediently verifies income and assets from many different sources; and 5) Lexis Nexus® - an investigative tool that will allow AHCCCS to effectively locate people and uncover assets that may not be disclosed in the application process.

IT Network Security – AHCCCS relies on network connectivity to deliver and support mission-critical services. To ensure the network is resilient and available to support critical applications (as well as a workforce that depends on availability of services and information), it is important to secure and protect the network against internal and external attacks. The agency is requesting $630,000 Total Fund ($359,800 General Fund) to fund this effort.

IT Vision – Extensive resources are needed to maintain and update the existing Pre-paid Medicaid Management Information System (PMMIS). Due to the age of PMMIS, it is also increasingly difficult to locate technical staff knowledgeable in its databases and programming tools, which results in heavy and costly reliance on contracted consultants. Additionally, it is not uncommon for important projects to be delayed because they either impact or are impacted by an aging, but critical, PMMIS claims sub-system. AHCCCS requested funds in SFY 2008 to replace this system. However, because the cost of replacing the claims sub-system exceeded the amount requested at that time, AHCCCS is now requesting an additional 3.6 FTEs and $3,929,100 Total Fund ($846,300 General Fund) for this first phase of a PMMIS replacement. Once the claims component has been successfully replaced, other sub-systems (e.g., encounters and reinsurance) will follow.

Equipment Replacement – AHCCCS is requesting $2,935,700 Total Fund ($1,713,800 General Fund) to replace obsolete and unsupported equipment, as well as outdated software. Regular replacement of hardware and software greatly lessens the number and cost of equipment failures and incompatible software occurrences. As outlined in the AHCCCS strategic plan, replacing outdated IT equipment is critical to maintaining cost controls and supporting agency growth.

Business Continuity Planning - For SFY 2009, AHCCCS requires funding of $1,052,000 Total Fund ($505,300 State Match) to fully implement its business continuity plans for the agency's network-based computing services. By adding necessary equipment, the major AHCCCS computer systems will be able to continue to operate in the event of a service interruption or disaster that impacts the central information centers. It is imperative that critical functions such as PMMIS, AHCCCS Customer Eligibility, Oracle Financials, Imaging, Web transactions, and Call Centers continue to operate without interruption.

Health Information Exchange and Electronic Health Record (HIeHR) Utility Operations – AHCCCS has requested 6 FTEs and $1,546,300 Total Fund ($486,500 General Fund) to develop an HIeHR Utility. This Utility will transform the AHCCCS Medicaid program and the patient care process to ultimately provide timely patient health information at the point of service, thereby improving quality of care and reducing costs.

Expansion of the Pre Determination Quality Control (PDQC) Unit – A first line of defense for fraud within the eligibility process, the PDQC unit conducts investigations before an applicant's eligibility is determined. To address staffing shortages, AHCCCS is requesting 6 FTEs and $430,300 Total Fund ($215,200 General Fund) that will be used to shield a greater number and percentage of applications from fraud.

COLLABORATION and INTEGRATION of Health Care Programs

***A** major variable in the success of the AHCCCS Strategic Plan, and a critical component associated with the aforementioned key issues and their respective strategies, is the ability to form effective partnerships with key stakeholders. Successful collaboration increases capability, multiplies resources, fosters communication, improves continuity of care, and limits the duplication of costly services.*

Importance to Strategic Planning

Today's health care environment is one of increasing demands and diminishing resources, creating a challenge to sustain access to effective care for recipients and improve efficiencies for delivery systems. Recent literature suggests that the traditional "silo" model of multiple agencies administering multiple programs by themselves is giving way to one-stop services and cross-agency results. This change implies collaboration – within agencies; among agencies; among levels of government; and among public, private, and non-profit sectors.

Collaboration should be an integral part of the goals and strategies designed to support and influence the issues, initiatives, and key topics addressed in this plan. This is due to a variety of circumstances, including:

- An increasing need to control costs by leveraging resources
- A growing idea of government as a series of enterprises rather than a series of agencies
- A blurring of public and private roles
- An increased use of technology, making it easier to share resources and information

A recent study involving a survey of 412 government representatives, primarily from state and local levels, examined the effectiveness of cross-agency investment, particularly in information technology (IT) infrastructure. Better information collection and distribution as well as customer service were the primary benefits realized by all cross-agency IT initiatives.

Medicaid agencies, in particular, have had increasing opportunities to participate in multi-agency efforts. A national survey of state systems addressed state agency activities and interagency collaboration related to employment opportunities for people with disabilities. The survey asked Medicaid agency representatives to indicate the specific methods used to collaborate with other state agencies. Based on the responses, methods of collaboration included three basic types:

- Activity Methods, such as cross-agency awareness training and the development of multi-agency groups, were most common.
- Structural Methods were longer-term, more involved approaches relating to physical and organizational structure, such as sharing physical space as well as IT networks and information.

- Financial Methods, such as sharing of funds across agencies, were effective but less common.

Arizona has already realized successes as a result of such approaches. A number of ongoing state programs exemplify the value of collaboration:

- Baby Arizona: This statewide project initiated by AHCCCS acts in partnership with other public and private organizations. The project promotes early access to prenatal care by streamlining eligibility for medical coverage for pregnant women and is perhaps one of the best examples of true collaboration. The program has been successful for nearly 12 years, facilitating timely prenatal care for many Arizona women.
- Hawaii and Arizona PMMIS Alliance (HAPA): HAPA is a collaborative project between the two state Medicaid agencies that allows for sharing of IT resources. The Prepaid Medical Management Information System (PMMIS) was designed specifically for Arizona's managed care Medicaid program. Under the agreement, Arizona runs and operates the application system for Hawaii's program as well as for its own. Both states share the costs of operation and maintenance of the core system, maximizing use of IT dollars.
- Medicaid School Based Claiming: This program is the result of an agreement between AHCCCS and the Arizona Department of Education (ADOE) that allows AHCCCS to use federal funds to reimburse school districts for medical services provided to Medicaid-eligible students in special education classes. Previously, these services were purchased by the schools with state-only funds. This leveraging of resources leads to more effective and efficient care for disabled children and reduces duplication of services.

Significance to AHCCCS

Arizona delegates responsibility for health concerns to more than one agency, making collaboration a vital process to ensure efficient and effective use of resources. AHCCCS presently works most frequently with both ADES and ADHS through intergovernmental agreements that affect matters such as eligibility determination and behavioral health system services. In addition, less formal collaborations exist between the agencies, addressing specific interests such as grant opportunities and public health initiatives. It is important that AHCCCS continue to partner with other entities and to formalize these collaborations to make them more effective and accountable for achieving mutually desired results. This means working with the staff of partnering entities to establish common expectations. A significant number of the programs administered by AHCCCS, ADES and ADHS involve mutual constituents. By maximizing opportunities for collaboration, we can achieve greater results using fewer resources and, ultimately benefit from the synergy that comes from working together.

"By maximizing opportunities for collaboration, we can achieve greater results using fewer resources."

Collaboration is not limited to sister state agencies. Key stakeholders in both public and private, sectors may collaborate on projects to improve health care availability and access. For example,

AHCCCS may collaborate with Federally Qualified Health Centers and telemedicine centers to improve access to care for AHCCCS recipients as well as the uninsured, employees of small businesses, state employees, and retirees. Collaboration may include working with small businesses to develop products that will meet their needs and budgets. Collaboration may involve working with AHCCCS providers to establish rates that more equitably compensate them for the costs of care.

AHCCCS approaches collaboration with the understanding that all participants stand to gain from the experience. By maximizing collaboration opportunities, AHCCCS expects to streamline and improve service delivery, realize cost savings as a result of greater efficiencies, and ultimately improve the health of all Arizonans.

APPENDIX:
TOTAL RESOURCES and ASSUMPTIONS

Membership and Financial Projections

A number of studies have documented the improved fiscal status of state revenues. However, health care economists are still concerned about the projected increases in health care costs for years to come. New technologies are significant cost drivers yet they yield important health care breakthroughs. Provider shortages either by geographic area or specialty can be addressed but generally require a significant amount of time to correct.

AHCCCS health plan weighted average capitation rates increased 6.1% for Contract Year 2008. The allocation for AHCCCS is currently at 12% of the state's general revenue fund with a projected increase to 16.2% in SFY 2013. As the largest health insurer in Arizona, with over one million members, AHCCCS expects some leverage to secure discounts and competitive rates. Because of the size and scope of the program, AHCCCS plays a key role in the local health care market in terms of volume and rate setting. Careful attention is needed to ensure equitable resource distribution through rate setting and negotiations.

The following table presents our budget estimates with associated assumptions:

Total SFY08 – SFY13 (Dollars are shown in thousands)

	SFY08 Approp.	SFY09 Budget Submittal	SFY10 Estimate	SFY11 Estimate	SFY12 Estimate	SFY13 Estimate
Full Time Equivalent (FTE)*	3,159.4	3,299.8	3,299.8	3,299.8	3,299.8	3,299.8
General Fund	$ 1,269,136	$ 1,508,845	$ 1,695,441	$ 1,902,303	$ 2,122,006	$ 2,363,036
Other Appropriated Fund	$ 238,045	$ 267,936	$ 290,432	$ 308,752	$ 328,833	$ 350,846
Non-Appropriated Fund	$ 478,515	$ 491,051	$ 481,640	$ 503,439	$ 527,375	$ 553,656
Federal Funds	$ 3,585,437	$ 4,057,563	$ 4,440,987	$ 4,874,667	$ 5,336,504	$ 5,843,394
TOTAL FUNDS	$ 5,571,133	$ 6,325,395	$ 6,908,500	$ 7,589,161	$ 8,314,718	$ 9,110,932

*FTEs include appropriated positions for or associated with ADES Eligibility pass-through funding.

Growth Assumptions:

Growth for SFY09 mirrors the SFY09 budget submittal by program.

Growth for SFY10 – SFY13 is based on the following assumptions:

- Member growth aligns with anticipated Arizona population growth (increase of 3.1%) as provided by the University of Arizona study in the July 2007 issue of *Arizona's Economy.*
- Rate growth assumes an overall average inflation of 6.5% per year.

Total Resource Assumptions

Dollars are shown in thousands:

All Issues	SFY09	SFY10	SFY11	SFY12	SFY13
FTE	61.6	-	-	-	-
General Funds	22,229,900	-	-	-	-
Other Appropriated Funds	552,700	-	-	-	-
Non-Appropriated Funds	2,905,700	-	-	-	-
Federal Funds	66,875,000	-	-	-	-
Total Funds	**$92,563,300**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

Notes: 1) Assumptions are either critical issues or decision packages within the agency's SFY09 Budget Submittal.
2) Future fiscal years are not shown as the agency is required to submit budget requests annually.

Other Notes

- Administrative costs are increased at a rate of 2.5% annually, and assume a federal match and fund split equal to the 2009 request. At this point, no additional FTES are added for 2009-2012, however, some of the administrative increases may relate to new FTES.
- HIFA parents program is assumed to continue through 2012.
- The amounts included in this report represent the AHCCCS appropriated budget only and do not include ADHS pass-through funding for behavioral health and CRS, ADES pass-through funding for DD LTC, School Based Services, or Healthcare Group Programmatic funding.
- Assumes the FFY09 FMAP of 66.16% (76.31% enhanced) will continue through 2013.
- The starting point is the SFY 2008 JLBC appropriations report and does not include any potential surplus/supplemental.
- Assumes that tobacco funding will remain constant at the SFY 2008 appropriated level. Any reduction to tobacco funding would require additional General Fund.

POPULATION INITIATIVE:
Responding to a Growing Aging Population

***F**or the first time in this country's history, the older population is growing faster than the general population. The baby boom generation, which includes individuals born between 1946 and 1964, is twice the size of its preceding generation and 50% the size of its succeeding generation. Between 2011 and 2020 these baby boomers will turn 65, creating the most dramatic age shift in history and straining government resources and health system capacities. Because of its sheer numbers and percentage growth, this cohort is likely to overwhelm the traditional responses of the family, the private sector, and the government. The increased need for long term care may outpace the supply, and the costs of health care and social services may extend beyond the reach of most elderly. Arizona, like the rest of the nation, will face the challenges of creating a safety net for an aging population in an environment in which taxpayers are proportionately decreasing. The good news is there is still time to plan and prepare for these significant changes. AHCCCS is committed to assuming a leadership role toward that end.*

"For the first time in this country's history, the older population is growing faster than the general population."

Environmental Scan

In addition to nationwide studies and census data, two major Arizona-specific endeavors provide a wealth of information useful in the assessment and understanding of an aging society. In the spring of 2002, Saint Luke's Health Initiatives completed *The Coming of Age*, a major research report on the status of aging in Arizona, particularly as it impacts future health care. In the spring of 2004, the Governor issued an Executive Order directing state agencies to develop plans to address the needs of the state's rapidly growing population of senior citizens. To date, these plans have been drafted and compiled and, following community input, will be finalized to form Arizona's *Aging 2020* initiative. Collectively, these resources offer a comprehensive picture of the senior population that is an imminent challenge to our health care system.

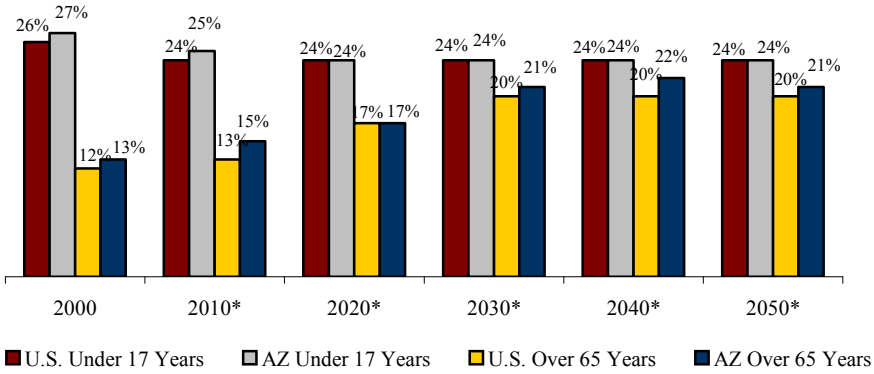
Demographics

Age

Population growth is based on measures of births, deaths, and migration. Similar to the national average, Arizona seniors, 65 years of age and older (≥65), currently account for approximately 13% of the state's total population, whereas Arizona residents 17 years of age and younger (≤17) currently account for approximately 26%. By 2025, however, the percentage of seniors ≥65 years is projected to increase to approximately 20%, whereas the percentage of residents ≤17

years is expected to decline slightly to approximately 24%, reducing the ratio of caregivers to care recipients. Between 2000 and 2025, Arizona's growth of Seniors ≥65 is projected to rank ninth in the nation.

Age-Specific Populations in Arizona and United States, 2000-2050*

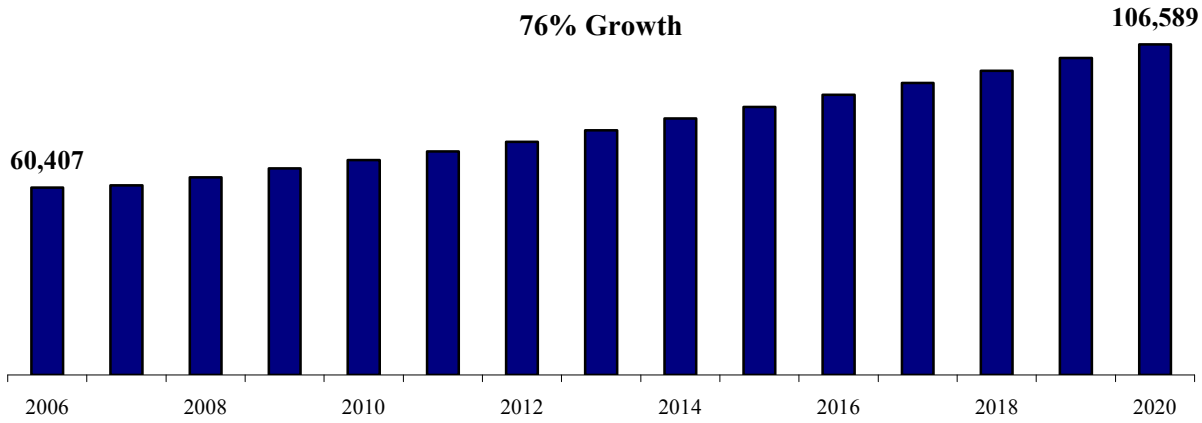


* Projected

Source: Arizona Health Futures

Individuals who move into Arizona, including the elderly, have played a major role in the state's population growth. Although the elderly comprise a relatively small proportion of this group, they tend to remain in place once they arrive. In fact, it is estimated that approximately one-half of the state's retirement age residents moved here after age 55.

Projected Number of AHCCCS Members (Ages 65+)



Sources: Arizona Department of Economic Security Projections by Age and AHCCCS Enrollment by Age.
Assumption: AHCCCS enrollment growth will increase for this age group in proportion with the increase in Arizona population for this age group.

The figure above illustrates the current AHCCCS population age 65 and older, and its potential for growth. Assuming AHCCCS growth is proportionate to that projected statewide, the volume of members age 65+ could increase approximately 76% by 2020.

Geographical Distribution and Growth

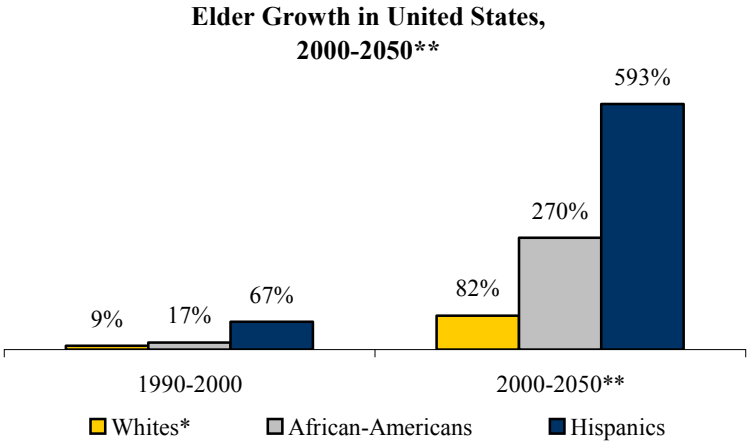
AGE 65+ POPULATION BY COUNTY						
County	Year 2000		Year 2020*		Year 2050*	
	Number	Percent	Number	Percent	Number	Percent
Apache	5,762	8%	11,354	13%	16,800	16%
Cochise	17,310	15%	37,619	22%	53,822	25%
Coconino	8,142	7%	21,230	13%	31,160	16%
Gila	10,164	20%	18,033	28%	24,175	31%
Graham	3,985	12%	6,740	16%	10,019	20%
Greenlee	846	10%	1,070	13%	1,262	14%
La Paz	5,086	26%	10,780	42%	14,510	47%
Maricopa	359,441	12%	764,055	15%	1,372,593	18%
Mohave	31,782	21%	82,747	29%	129,612	32%
Navajo	9,747	10%	24,351	17%	36,865	19%
Pima	119,812	14%	243,375	19%	391,309	23%
Pinal	29,116	16%	152,498	25%	369,766	28%
Santa Cruz	4,107	11%	9,854	16%	15,906	19%
Yavapai	36,854	22%	91,753	30%	142,095	34%

*Projected Source: AZ Department of Economic Security

The majority of Arizona residents live in Maricopa or Pima Counties, where most of the state's senior population growth is expected to take place. Nevertheless, as indicated above, a number of rural areas such as Gila, LaPaz, Mohave, and Yavapai Counties, are home to a higher proportion of elderly than the two urban counties. It is especially important to consider the magnitude of prospected age shifts by county. La Paz County, a primarily rural area just north of Yuma County, serves as a good example. The expected shift in percentage of elderly from 26% in 2000 to 42% in 2020 is the state's highest, and the dramatic increase in the elderly population proportion over time could significantly impact the local infrastructure. Attracting the elderly here are affordable housing; moderate temperatures, especially in winter; and close vicinity to California, Mexico, the Colorado River, and numerous recreational areas.

This is an important consideration, particularly since the majority of these rural elderly are expected to age in place. At the same time existing rural populations are aging, marketing efforts attempt to attract new retirees in an effort to further economic development. These two forces combine to create significant population changes. Moreover, over one-third of AHCCCS members age 65 and older reside in the state's rural communities. It is presumed that older individuals will continue to account for over one-third of rural residents. This reinforces the importance of planning for rural as well as urban populations.

Ethnicity



* Non-Hispanic. **Projected.
Source: Arizona Health Futures

According to national data, Hispanics accounted for the largest population growth (67%) between 1990 and 2000. This pattern is expected to continue until 2050, when the percentage growth of Hispanics is estimated to reach 593% nationwide.

Whereas the majority of today's elderly Arizonan's are white, tomorrow's elderly will be notably more diverse. In particular, growth among Hispanics is expected to outpace other groups, particularly in Arizona where, according to Kaiser, the Hispanic percentage of the state's population in 2006 (32%) is already notably higher than the national average (15%). Furthermore, the most recent census data shows that Arizona experienced a 39% increase in its Hispanic population between 2000 and 2006 compared with 26% Hispanic growth nationally. The Arizona Hispanic Chamber of Commerce reports that the state has the fastest growing Hispanic population in the nation.

Historically, the Hispanic population has tended to be "younger" than the non-Hispanic white population. Recent data, however, indicate that the median age has risen over the past decade, reinforcing the importance of cultural competence when planning responses to an aging population.

While Hispanics currently account for 32% of the state population, they account for 48% of AHCCCS members. Assuming that future AHCCCS ethnicity changes are consistent with those projected statewide, Hispanics could represent an even greater percentage of the 65+ AHCCCS membership in the future.

The Arizona Native American population, which currently accounts for 5% of the state total, is projected to remain stable. Native Americans presently account for 11% of enrolled members. Sensitivity to factors such as culture and language, especially in older individuals, has significant implications for patient compliance and reduction of health disparities.

Health Status

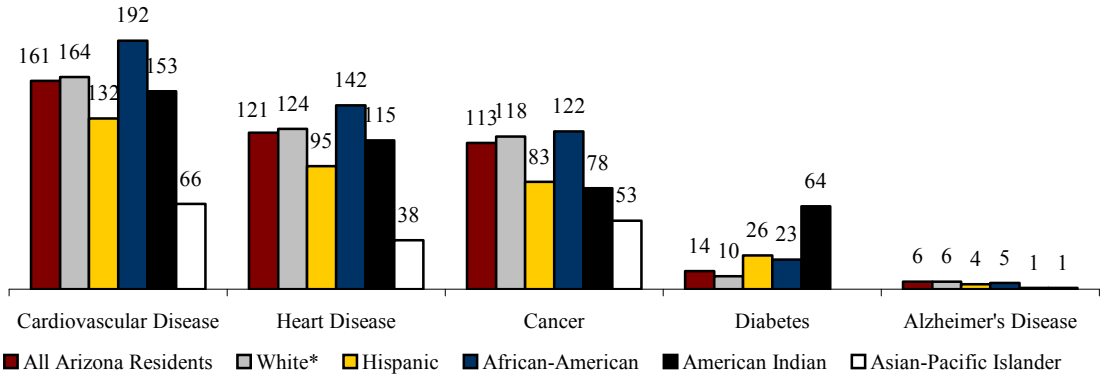
Americans will live longer in the 21st century than in any previous generation. The fact remains, however, that along with aging comes an increase in the number of individuals living with one or, frequently, more than one chronic condition. The growing number of those with chronic conditions will be seeking care in a system that is accustomed to delivering uncoordinated services to individuals with immediate acute needs. It is not a system that has ample networks of care or experience coordinating care across a service continuum for people with multiple chronic conditions.

Estimates indicate that, in 1996, 99 million people in the United States suffered from chronic conditions. By 2002, those numbers increased to more than 125 million, or nearly half of all Americans. By 2020, as the population ages, this number will increase, and many will have multiple conditions that cause functional limitations and disabilities. Recent estimates are that nearly half of all people with chronic conditions have multiple chronic conditions. By 2020, it is estimated that 81 million will have two or more chronic conditions and at least 25% of this number will have activity limitations.

In some respects, Arizonans may be healthier than residents of other states (e.g., the death rate is less than for the nation as a whole). Many other indicators, however, deserve attention, particularly as they impact the health of the elderly. According to ADHS, arthritis and high blood pressure affect elders most often, and a growing problem of obesity impacts both of these conditions. Also, up to 25% of older Arizonans may suffer from mental health problems, commonly depression and anxiety.

An important demographic concern regards the differences in medical conditions among the state's racial and ethnic groups. A better understanding of these differences lends insight to the variety of health needs among the elderly and, in addition, provides an opportunity to address concerns proactively.

Deaths per 100,000 in Arizona, 1999



*Non-Hispanic.
Source: Arizona Health Futures

The figure above presents death rates by disease type and ethnicity. It seems clear that, as the population ages and becomes more diverse, there are increasing opportunities for health care providers to develop tailored disease management programs. For example, the education and management of elderly Native Americans with diabetes calls for unique programming strategies.

Caregiver Resources

The aging population will bring with it increased needs for medical care delivery, particularly long term care services and support systems. Over the next 15 years, the number of people who need long-term care is expected to increase by 30%. After that, the number will increase even

more dramatically until 2050, when the number of people with long term care needs is estimated to double. This concern is compounded by the fact that, at a time when the number of people needing long term care is likely to increase substantially, the overall labor force relative to the size of the population is likely to be smaller than it is today. This affects both formal e.g., professional) and informal (e.g., family) health care resources.

Currently, Arizona has over 1,500 hospitals, clinics, nursing homes, and assisted living facilities, the majority of which are located in Maricopa and Pima Counties, the current state population centers. This is problematic given the anticipated needs of the over one-third of the state's elderly who reside in rural communities.

Multiple factors affect formal health care resources. In particular, liability insurance costs for nursing home facilities and physicians have risen dramatically. The cost of claims for the past three years is estimated at over $2 billion, and the average medical insurance premium cost is over 200% higher than it was in 2001. These rapidly increasing costs are a major challenge, especially for smaller providers serving the elderly in rural communities.

It is significant that Arizona has comparatively fewer doctors and nurses per 100,000 population than is found nationwide. In addition, it is a relatively unstable workforce, as the turnover is significant and the average tenure is short. The issues are similar among non-professional caregivers, who describe demanding conditions and, often, inadequate compensation. It is important to remember that aging is an issue for workers as well as for recipients of service. An increasing number of health professionals will soon age out of the workforce.

Multiple factors also affect informal health care resources. The percentage of elderly needing care is outpacing the percentage of younger individuals capable of providing that care. Families are decreasing in size, and adult children pressed into service are likely to have fewer siblings to turn to for respite. Increased mobility also increases the likelihood that children live farther away from their parents. Dual-income families leave neither spouse available to provide full-time care. In addition, people are living longer, lengthening the time that care may be required.

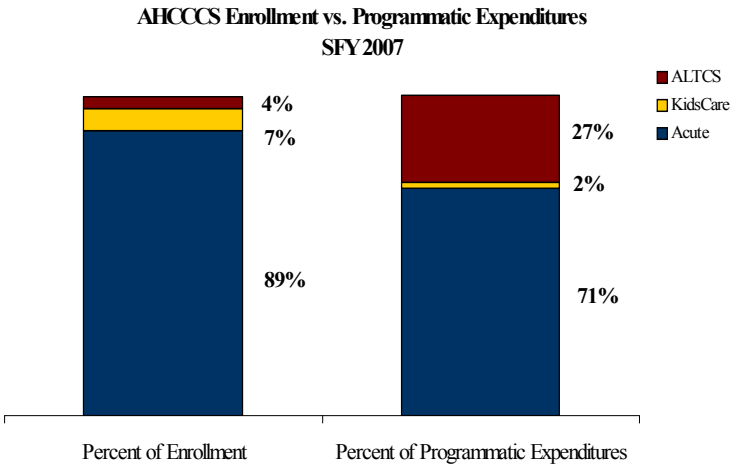
All of these factors have an impact on informal caregivers as well, as they juggle a myriad of financial, physical, emotional, and medical responsibilities. Ultimately, this may place a greater burden on formal caregivers, whose numbers are already insufficient to meet current needs.

Significance to AHCCCS

From its inception in 1982 until 1988, AHCCCS covered services to an acute care population only. In November 1988, the program was expanded to include the Arizona Long Term Care System (ALTCS) for elderly and physically disabled (EPD) and developmentally disabled (DD) populations. Based on their health status, members age 65 and older may be enrolled in either the acute or long term care program. The majority qualify for Medicare benefits. However, because of their income status, they depend on AHCCCS or ALTCS for cost-sharing and critical services uncovered by Medicare.

Unlike programs in other states that rely solely on fee-for-service reimbursement, AHCCCS provides prospective payments to AHCCCS-contracted health plans and ALTCS program contractors. The result is a managed care system that mainstreams recipients, allows them to choose their providers, and promotes the coordination of quality care across all age groups.

Whereas ALTCS members account for only 4% of the over one million AHCCCS enrollees, they account for approximately 27% of total AHCCCS expenditures. Thus it is important that Arizona, one of the fastest growing states in the nation, prepare for an aging population through innovative, sensitive, and cost-effective programs



*Excludes HCG and Medicare Cost Sharing Programs.

In its role as the Medicaid provider to both acute and long term care populations, AHCCCS is uniquely positioned to provide an entire continuum of services and settings that impact an aging population. Programs that promote health and emphasize the prevention and management of chronic diseases ensure efficient use of public resources and create a positive difference in the quality of life for aging Arizonans. A range of settings and services that offers flexibility and favorable alternatives to institutionalization is equally important.

Key Issues and Current Responses

As the provider of acute and long term health care coverage to approximately 17% of the Arizona population, AHCCCS must address some key issues vital to changing demographics, particularly as they affect an aging population. The issues both impact and are impacted by this strategic plan, which establishes a commitment to: (1) control medical cost inflation, (2) improve health care quality and accessibility, (3) reduce the volume of uninsured, and (4) enhance organizational capacity. These four imperatives guide current and future policy and program responses to the demographic aging issues identified above.

Costs and Funding

In a climate of steadily rising health care costs and limited funding, the economic consequences of demographic aging present a critical challenge. As the percentage of seniors increases, the per capita cost of health care is likely to increase. Present state and federal funding sources for Medicare and Medicaid may prove to be structurally insufficient to support these changing demographics. Both long term financing reform and fiscal responsibility emerge as major

considerations in addressing care for an older population. Medicaid is currently the primary source of long-term insurance coverage for the elderly and disabled, including middle-income individuals who exhaust their assets as a result of long term care. Funding these services places considerable burdens upon state Medicaid budgets.

- ALTCS takes advantage of federal waiver opportunities to offer a flexible long term care system, and has established principles, programs and payment strategies that encourage and support the delivery of cost-effective, quality services in the least restrictive settings.

- Currently, approximately 63% of the ALTCS elderly and physically disabled populations reside outside an institutional nursing facility. The cost to provide services to an individual in his/her own home or community is one-third the cost of a nursing facility bed, and survey research indicates that older adults overwhelmingly prefer to remain in their own homes as long as practical. ALTCS covers an extensive range of home and community-based services (HCBS), and has continued to explore and expand coverage of additional types of assisted living facilities that allow members alternatives to institutionalization.

- An estimated 20% of Arizonans lack health insurance. Efforts to reduce the uninsured population in Arizona are vital to ensuring accessibility to care and, ultimately, maintaining the health of an aging population in a cost-effective manner. AHCCCS administers Healthcare Group, which offers affordable premium based insurance to small businesses. Over 46% of the small business employees covered by HCG are age 50 and older. This is a group that often has difficulty obtaining affordable coverage.

Unique Health Care Needs

As explained above, an aging population means an increase in the number of individuals living with one or more chronic conditions and seeking care in a system that is, in large part, structured to respond to acute care needs. AHCCCS is challenged to respond proactively by supporting preventive measures and coordinating quality care and disease management for members of all ages, throughout all programs, and across an entire continuum of services.

- A critical response to demographic aging and its accompanying chronic care burden is the prevention or early recognition and management of disease and disability in individuals of all ages. AHCCCS covers annual wellness examinations and screening procedures for an array of diseases (e.g., cervical cancer, prostate cancer) and offers multiple health education programs (e.g., nutrition, smoking cessation) designed to encourage healthy lifestyles at all ages.

- To facilitate the earliest possible identification of members who may benefit from care coordination, disease management, or some other population-specific assistance, AHCCCS requires contracted health plans to conduct health risk assessments on all new members.

- AHCCCS places significant importance on immunizations, including influenza and pneumonia immunizations for adults. Tracking and outreach is particularly important in

light of recent data suggesting that flu and pneumonia immunizations for frail adults contribute to decreases in illnesses, hospitalizations, and nursing facility admissions.

- A total of six AHCCCS health plans and program contractors have obtained "Special Needs Plan (SNP)" status. SNPs qualify as Medicare Advantage Plans that focus on individuals with special needs, such as those who are eligible for both Medicare and Medicaid (dual-eligible members). The objective of the SNPs is to improve continuity and quality of care while reducing duplication of services and controlling costs.

Availability and Accessibility of Care

Changing demographics will only magnify current issues related to the availability and accessibility of health care. Because the elderly have an increased need for health care services, and because the number of formal and informal health care providers could be inadequate to meet the need, the healthcare workforce must increase in greater proportion than the overall 65% growth projected for Arizona's senior population. This presents a challenge since Arizona currently claims fewer doctors and nurses than the national average, and paraprofessionals are seeking alternative jobs that offer greater satisfaction and salaries. Family caregivers, who previously assumed 70% of the care for their elders are also aging and may be unable to continue in caregiver roles without additional support. Future strategies must address barriers to the adequacy of both workforce and settings.

Geographical concerns add another dimension to issues of accessibility. Although a majority of Arizona's older population resides in urban counties (i.e., Maricopa and Pima), a number of rural counties include a greater proportion of elderly residents than urban counties. Almost one third of the population age 65 and older resides outside primarily urban areas. This rural population is likely to increase, challenging AHCCCS to assess new strategies to support the growth of local health care infrastructures and evaluate emerging technological opportunities such as telemedicine.

- ALTCS contractors are required to submit an Annual Network Development and Management Plan that analyzes the current status of their networks, identifies gaps and delays in service, and describes strategies for improvement. These plans promote the identification of issues and potential solutions to meet the needs of members. In addition, ALTCS contractors use member-provider councils to represent respective stakeholder communities. Council member feedback assists contractors in identifying unmet needs.

- The most recent AHCCCS contract with ALTCS program contractors specifically encourages them to participate in the development of a direct caregiver workforce. Because program contractors constitute the largest payer group for paraprofessionals in the long term care market, they must leverage this to ensure adequate resources in the future. The program contractors must have, as part of their network development plan, a component regarding paraprofessional work force development in nursing facilities, alternative residential facilities and in-home care situations. Workforce development includes actions related to the active recruitment and pre-employment training of new caregivers and opportunities for continued

training of current caregivers. It also includes efforts to review compensation and benefit incentives.

- In support of workforce development, AHCCCS was awarded a grant entitled "Direct Service Workforce Development Intensive Technical Assistance to States," sponsored by CMS. Arizona was one of five states selected to receive technical assistance throughout 2007. The grant provides assistance to the ALTCS program to ensure the availability of direct service workers to provide home and community based services. Expert staff from the CMS Direct Service Workforce Resource Center will assist the state in developing policies, support mechanisms, monitoring mechanisms, and evaluation tools related to consumer-directed care and reimbursement of spouses as paid caregivers. The Governor's Citizens Workgroup on the Arizona Long Term Care Workforce Report, issued in April 2005, identified these as two key strategies for ensuring a sufficient and capable workforce.

- ALTCS currently pays for services rendered by family members. Today, approximately one-half of all paid caregivers are family members. Sustaining that percentage is critical to the maintenance of an adequate caregiver force.

- Because the burden on care-giving spouses may extend far beyond ordinary obligations and contribute to job loss and financial burdens, AHCCCS sought and received a federal waiver that allows spouses to be eligible for reimbursement for care-giving activities. To ensure integrity of this process, the paid spousal care-givers must meet established criteria and the services they provide must be monitored regularly.

- AHCCCS is a major participant in a variety of councils and work groups, including the Interagency Council on Long Term Care, the Governor's Council on Aging, and the Governor's Citizen's Work Group on the Long Term Care Workforce. With the support of multiple stakeholders, these collaborations identify gaps in services and facilitate mutual improvement efforts.

- Behavioral health services are a necessary component of care for a significant number of ALTCS members. Effective coordination of behavioral and medical case management reduces costs by facilitating more timely discharges from acute facilities and more appropriate use of community resources.

Ethnic Diversity

Older Arizonans may be more diverse in their ethnicity and their health needs. Currently, Hispanics account for 32% of the state population but 48% of the AHCCCS population. Native Americans account for 5% of the state population but 11% of the AHCCCS population. Sensitivity to factors such as culture and language, especially in older individuals, has a significant impact on patient compliance and health care disparities.

- AHCCCS requires contracted health plans to address cultural competency education and concerns about its network.

- AHCCCS supports a comprehensive diabetes management program that is especially important to Native Americans who have a high incidence of the disease.

AHCCCS Organizational Capacity

The AHCCCS workforce is not immune to an aging demographic, and serves as an example of the challenges confronting the community-at-large. Without attention to employee recruitment, retention, and succession planning, the estimated growth in employee attrition will significantly impact the agency's ability to fulfill its mission. As of November 2007, approximately 1,360 persons are employed at AHCCCS. Current analyses indicate that 39% of the agency's workforce will reach retirement age by the year 2020. Additionally, almost 7% of this number have already accumulated, or are within one year of accumulating, the total number of points (80) required for full state retirement benefits. For the next five years this rate will increase substantially, almost tripling in 2013, accelerating the loss of highly skilled employees, while simultaneously escalating costs to replace them. Retirement projections are: 7.0% (2008), 9.2% (2009), 12.5% (2010), 15.8% (2011), 19.6% (2012), and 23.6% (2013). These rates are further compounded by non-retirement separations.

Recommended Strategies

The previous section described current AHCCCS endeavors that affect a variety of issues related to a growing aging population. This section summarizes additional strategies important to AHCCCS as it prepares for the approaching age shift. More detailed information regarding these strategies may be found in two additional documents: (1) The Aging Plan developed by ALTCS to guide and support long range planning for long term care, and (2) The AHCCCS response to Aging 2020, the Governor's state aging initiative.

Consider Demographic Aging in the Development of Health Care Quality Improvement Processes and Benefit Designs

- Identify and expand culturally competent health education opportunities for individuals of all ages and promote wellness throughout the aging process. In particular, focus on obesity, which has definite consequences for an aging population, increasing the risks involved with such diseases as arthritis, diabetes and hypertension.

- Cooperate and collaborate with ADHS to enhance outreach efforts and improve participation in preventive services (e.g., obesity programs, adult immunizations).

- Support "universal building" efforts extended by the Department of Housing. Universal building requirements impact senior safety and eliminate the need for future AHCCCS coverage of structural revisions (e.g., rails, ramps).

- Investigate alternatives for financing currently uncovered services that are vital to senior independence and quality of life, specifically vision, hearing, and dental services. These

services, which are not currently covered by Medicare or Medicaid, can be significant determinants of senior independence.

- Coordinate the development and implementation of evidence-based practice guidelines for chronic diseases and identify centers of excellence as well as providers with exceptionally good outcomes.

Prepare an Adequate and Appropriate Delivery Network

- Ensure the stability of nursing home facilities, hospitals and other critical providers through equitable reimbursement rates, and the support of efforts that address unsustainable malpractice premiums.

- Investigate opportunities to facilitate provider recruitment and retention efforts, particularly in underserved areas, by (1) supporting the infrastructure of Federally Qualified Health Centers (FQHCs) and other existing providers (including direct caregivers), (2) cooperating with state medical schools to support professional training programs that produce gerontological specialists and fill gaps in medical service availability, (3) expanding the use of physician extenders (i.e., nurse practitioners and physician assistants), and (4) developing more informal and community resources to improve the continuum of care.

- Implement Consumer Directed Care (CDC) as an option for ALTCS elderly and physically disabled members. CDC offers more autonomy to ALTCS members who are receiving home and community based services, allowing them to direct and manage their own care needs. Members may choose to receive their care through provider agencies or hire independent caregivers. A popular model of CDC is the "Fiscal/Employer Agent Model," that recognizes the member as a common-law employer of a caregiver. Evaluations of these types of programs indicate that member choice, control, and responsibility improve service quality, expand the workforce, and provide flexible support and service.

- Evaluate the return on investment resulting from a "Transitional Service." This service would provide Medicaid dollars to assist with a member's transition from an institutional setting to a less-costly in-home setting. Funding may assist members with rental deposits, utilities payments, and household start-up costs, ultimately facilitating transition from an institutional setting to HCBS.

- Assess the feasibility of prior period coverage for HCBS and, if appropriate, seek a waiver from CMS. This policy change would provide for maximization of HCBS utilization, reduction in nursing facility utilization, and resultant cost savings.

- Ensure the continuance of incentives that promote the use of cost-effective HCBS placements without compromising quality of care.

- Facilitate and support caregiver education through collaborative partnerships, and ensure ongoing access to useful caregiver resources.

- Improve accessibility to care by investigating opportunities to enhance medically necessary transportation services.

- Reform the share of cost system in order to facilitate improved dental access for the elderly.

Maximize Use of Information and Technology

- Enhance information systems to improve the ability to collect and analyze pertinent data, particularly related to senior health issues. Assess the feasibility of developing a cost-effective information system that is capable of integrating data from multiple sources (e.g., eligibility assessments, health service encounters, pharmacy encounters, case management evaluations, and care plans) for the purpose of enhancing Case Management, Assessment, and Planning (CMAP) activities.

- Review and enhance the AHCCCS website to ensure its suitability for an aging population (e.g., large font options, user-friendly directions, adaptations for disabilities), and recognize that the web may provide many applications in the future that do not exist today.

- Evaluate the efficiency, effectiveness, and cost-benefit of technological advancements that allow individuals to remain safely in their homes (e.g., assistive devices, medical monitoring, and telemedicine).

POPULATION INITIATIVE:
Native American Health Care

Arizona is home to approximately 277,732 Native Americans, nearly half of whom are enrolled in AHCCCS. Whereas the Native American population accounts for only 5% of the total state population, it accounts for 11% of the Arizona Health Care Cost Containment System (AHCCCS) population. Historically, the burden of illness among Native Americans has been significantly greater than that of the general population. The nature and scope of Native American health disparities has been attributed to a variety of issues that include social and cultural barriers, legislative and financial concerns, and persistent structural problems. For example, the actual delivery and documentation of Native American health services is frequently divided between multiple providers, fragmenting the continuum of care and disrupting the flow of important health information. AHCCCS faces significant challenges in its role as a major source of health care services to Native Americans and is committed to developing and implementing strategies that ultimately lead to improvements in health status.

"Arizona is home to approximately 277,732 Native Americans, nearly half of whom are enrolled in AHCCCS."

Environmental Scan

Demographics

Population

Native American Population Distribution: US vs. Arizona vs. AHCCCS

Race	United States		Arizona		AHCCCS	
	Number	Percent	Number	Percent	Number	Percent
NA	2,369,431	1%	277,732	5%	117,440	11%
Non-NA	297,029,054	99%	5,888,586	95%	965,153	89%
Total	299,398,485	100%	6,166,318	100%	1,082,593	100%

Arizona has the seventh largest Native American population in the nation. Whereas Native Americans account for approximately 1% of the United States population, they account for approximately 5% of the Arizona population and 11% of the AHCCCS member population. As nearly one-half of the state's Native Americans are enrolled in AHCCCS, opportunities exist for the agency to promote policies and deliver health care that positively impacts the future of this population.

Age

General and Native American Populations by Age: US vs. Arizona vs. AHCCCS

Age	United States		Arizona		AHCCCS	
	General	NA	General	NA	General	NA
<21	30%	38%	31%	44%	56%	55%
21-64	58%	56%	56%	50%	38%	40%
>64	12%	6%	13%	6%	6%	5%
Total	100%	100%	100%	100%	100%	100%

The above table demonstrates that the age distribution of Native Americans in Arizona is reasonably similar to that of Native Americans across the nation. When Native Americans are compared with the total general population (Native Americans and non-Native Americans), however, they include a substantially higher percentage of children and a substantially lower percentage of older adults. The higher percentage of children, evident across national, state and AHCCCS data, is consistent with a projected 40% growth in the Native American population between 2000 and 2025. This is compared to a projected growth in the total population of 23%. The lower percentage of older adults is consistent with data indicating that Native Americans live almost eight years less than the total population.

Geographical Location

Native Americans contribute significantly to Arizona's cultural diversity. The state is home to 22 federally recognized tribes. Reservations and tribal communities are located in both urban and rural areas throughout the state, comprising approximately one quarter of Arizona land. Of those Native Americans receiving AHCCCS benefits, approximately 42% reside on reservations.

Economic Status

Economic Characteristics: US vs. AZ: General Population vs. NA Population

Characteristic	United States		Arizona	
	General Pop	NA Pop	General Pop	NA Pop
Median Household Income	$41,994	$30,693	$40,558	$24,514
Below Federal Poverty Level	12%	26%	14%	36%

The above table demonstrates some disconcerting facts related to Native American economic status. According to national census data, Arizona Native Americans have lower household incomes and higher federal poverty levels than both national and statewide general populations. In addition, they have lower incomes and higher poverty levels than fellow Native Americans nationwide. All these factors contribute significantly to disparities in health status.

As a result of the growing gaming industry, a perception exists that Native Americans have begun to receive all the funding that they need, and that federal assistance is no longer necessary. This perception is inaccurate for several reasons. First, it ignores the federal trust obligation to provide health care to Native Americans in federally recognized tribes. Secondly, it exaggerates the amount and influence of gaming profits. In reality, approximately one-half of all tribes have casinos, and only a small number of those have been particularly successful. Many barely break even because of inadequate size or poor location, and much of the gain goes to non-Indian investors. Although some tribes have applied a portion of their increased revenue to health care, the majority continues to rely on Medicaid and funds appropriated to IHS.

Health Concerns

Native Americans suffer disproportionately from a variety of illnesses that not only affect health status, but impact economic, educational, and social development as well. Inadequate access to basic care, poor living conditions, poverty, remote geography, and alcohol and substance abuse continue to undercut the progress made in health delivery systems. Particularly disturbing is the fact that a significant number of conditions related to high morbidity and mortality rates are directly affected by individual lifestyle choices.

Diabetes

Diabetes mortality among Native Americans is 3.1 times higher than that among the general population, and the prevalence of the disease is 16.3% for Native adults, compared with 8.7% of non-Hispanic whites. The following increases in prevalence were documented between 1990 and 2002 by age groups: 132% (ages 25-34), 69% (ages 20-24), and 106% (ages 15-19).

Among the Native American population with diabetes, 95% have Type II. This is a troubling fact when one realizes that Type II diabetes is a condition that is largely preventable with lifestyle changes. In fact, the highest prevalence of diabetes in the world is found in Arizona's Pima (Tohono O'odham) Tribe, with half of all adults having adult-onset diabetes. Changing agricultural conditions have led to crop reductions and reliance on commodity foods. According to IHS, the average annual medical care cost of one individual with diabetes is $13,243, compared with $2,560 costs for one without diabetes.

A major concern regarding the prevalence of Type II diabetes is that it has increasingly affected Native American children. The incidence is increasing at a faster rate among children and young adults than among any other ethnic population. IHS reports a 45% increase in the prevalence of diagnosed diabetes among all ages served by the Indian Health Service. The highest rate of increase has occurred among young adults aged 25-34 years, with a 160% increase between 1990 and 2004; during the same period, Type II diabetes rose 128% in youth between 15 and 19 years of age.

Cardiovascular Disease

Cardiovascular disease has increased dramatically among the Native American population in recent years. According to the IHS, heart disease has become the leading cause of death, and stroke has become the fifth leading cause of death. Native Americans have cardiovascular disease rates twice that of the general population, and the risk of stroke among younger

individuals is reported to be as much as twice as high as all ethnic groups combined. These remarkable rates may be attributable, in part, to diabetes, hypertension, and other risk factors that include poor eating habits and sedentary lifestyles. In fact, 66% of Native Americans with cardiovascular disease had diabetes first.

Mental Health Disorders

Native Americans are at higher risk for mental health disorders than any other racial or ethnic group in the nation. The most significant current mental health problems include a high prevalence of depression, anxiety, violence, and suicide.

"Suicide is the second leading cause of death for Native Americans aged 10-34 years."

Depression, which has become a principal concern, is commonly associated with isolation, poverty, and hopelessness. Its toll on Native Americans is reflected in high suicide rates. Suicide is ranked as the eighth leading cause of death for Native Americans of all ages; and, it is 72% greater than the national average. Suicide rates are particularly high among young males in the 15-24 year old age group. In fact, the Centers for Disease Control (CDC) reported that from 1999 to 2004, these Native American males had the highest suicide rate (27.99 per 100,000), compared to white (17.54 per 100,000), black (12.80 per 100,000), and Asian/Pacific Islander (8.96 per 100,000) males of the same age. Suicide is also the second leading cause of death for Native Americans aged 10-34 years.

The CDC also reports that mental health services are not easily accessible to the Native American population, due to funding limitations, culturally-inappropriate services, and mental health professional shortages as well as high turnover. For these reasons, Native Americans tend to underutilize mental health services and prematurely discontinue therapy.

Substance Abuse

Although technically categorized as mental health disorders, substance abuse is considered separately here because of its significant impact on the Native American population. The most recent data reported by IHS shows that between 1992 and 2002, alcoholism mortality rates in some Tribal communities have increased to nearly seven times the alcoholism death rate of the overall U.S. population. One of a number of findings associated with alcohol abuse is that of Fetal Alcohol Spectrum Disorder (FASD)—the most preventable cause of mental retardation—which is caused by heavy drinking during pregnancy. Rates of FASD are higher among Native American women than the general population. In addition, the drug-related death rate is 18% higher than the rate for the overall U.S. population. Among 12-17 year-old Native American youth, the 23% rate of current illicit drug use is the highest nationally. Methamphetamine use is on the rise. It is estimated that a 30% increase in patients seen between FY 2004 and FY 2005 were for methamphetamine use.

Cancer

Despite the fact that cancer incidence rates have tended to be lower among Native Americans than among other racial groups, Native Americans have the poorest cancer survival rates of any racial group in the United States. Contributing factors include late detection, poor compliance with treatment, the presence of accompanying disease, and lack of timely access to diagnosis and

treatment. Within the last 30 years, cancer has become a leading cause of death for Native Americans of all ages.

Injuries, Trauma

Unintentional injuries are the leading cause of death for Native Americans under the age of 44 and the third leading cause of death overall. The age-adjusted injury death rate of Native Americans is approximately 250% higher that that of the general U.S. population. Further, Native Americans experience injuries one and one-half to five times more frequently than non-Native Americans. As a result, IHS spends over $150 million annually treating unintentional injuries.

A recent analysis by the Arizona State University School of Health Management and Policy concluded that Arizona's Native American children are more likely to experience accidents, homicide, and suicide than are children among all other ethnic groups. Further, deaths among Native American children are more likely to be preventable.

"…Arizona's Native American children are more likely to experience accidents, homicide, and suicide than are children among all other ethnic groups."

Obesity

Obesity is a major challenge to the health status of Native Americans, particularly because of the relationship it shares with Type II diabetes. A variety of studies of Native American children and adults confirm a high prevalence of overweight and obesity. One study found that 80% of Arizona's Pima Indians were overweight. There are multiple explanations for this circumstance that relate to both genetic predisposition and diet. The fact remains, however, that, because of the significant role of obesity in the development and course of other conditions, attention to further study and intervention is essential.

Oral Health Problems

Native Americans experience wide gaps in oral health services. When compared to the general population, their access to care and utilization of services is markedly limited. Recent figures suggest that approximately 75% of Native Americans may be going without dental visits, and their rate of oral disease may be twice that of any other group across the nation.

In particular, the prevalence and severity of dental caries in Native American children are substantially higher than in any other non-Indian children's group. A 1999 Oral Health Survey conducted by Indian Health Services indicated that 68% of Native American children had untreated decay. Mean scores for Native American children with diseased, missing and filled surfaces (DMFS) are over 200% higher than for non-Native American children. In addition, children five years of age and younger have corresponding early childhood caries rates of 50% to 80%. The rate of dental caries among Native Americans is six times higher that the rate of caries among Caucasians, and the highest of any ethnic group in the United States. The national average rate of caries for all children is under 10%.

Developmental Disorders Affecting Communication: Speech, Language, Hearing

A variety of sources report that communication disorders occur more frequently among Native Americans than among the general population. Some estimate that the frequency of communication disorders occur five to 15 times more in Native Americans, whereas the special education services available for these impairments occur with less frequency. Specifically, access to special education personnel is a problem for Native American families residing in rural and remote communities.

Health Care Delivery System

Historical Perspective

The health care delivery system for Native Americans is the result of a complex and often inconsistent history of relations between the tribes and the U.S. government. The Kaiser Foundation recently published an issue brief on the roots of Native American health care. The brief offers an interesting summary of the legal and historical background against which the Native American health care system exists.

Brett Lee Shelton, who prepared the Kaiser document, aptly explains that, as part of an ever-changing landscape, different policies (e.g., termination, assimilation, self-determination) existed during different periods. Following each period, "threads" of doctrine remained, each affecting the current health care system for Native Americans. Tribal sovereignty, government-to-government relations between the tribes and the U.S., and tribal autonomy have been common themes underlying federal-Native American relations. In conjunction with these themes, U.S. policy preferences have shifted back and forth between termination, assimilation and self-determination.

In the end, history and policy preferences have played and continue to play a significant part in the delivery of Native American health care. Although the federal government has a trust responsibility to protect health care for Native Americans, the system lacks adequate funding, staff, and organization to carry out this task. As a result, public programs, such as Medicaid, have assumed an increasingly important role in the delivery and financing of care to Native Americans.

National Structure and Funding

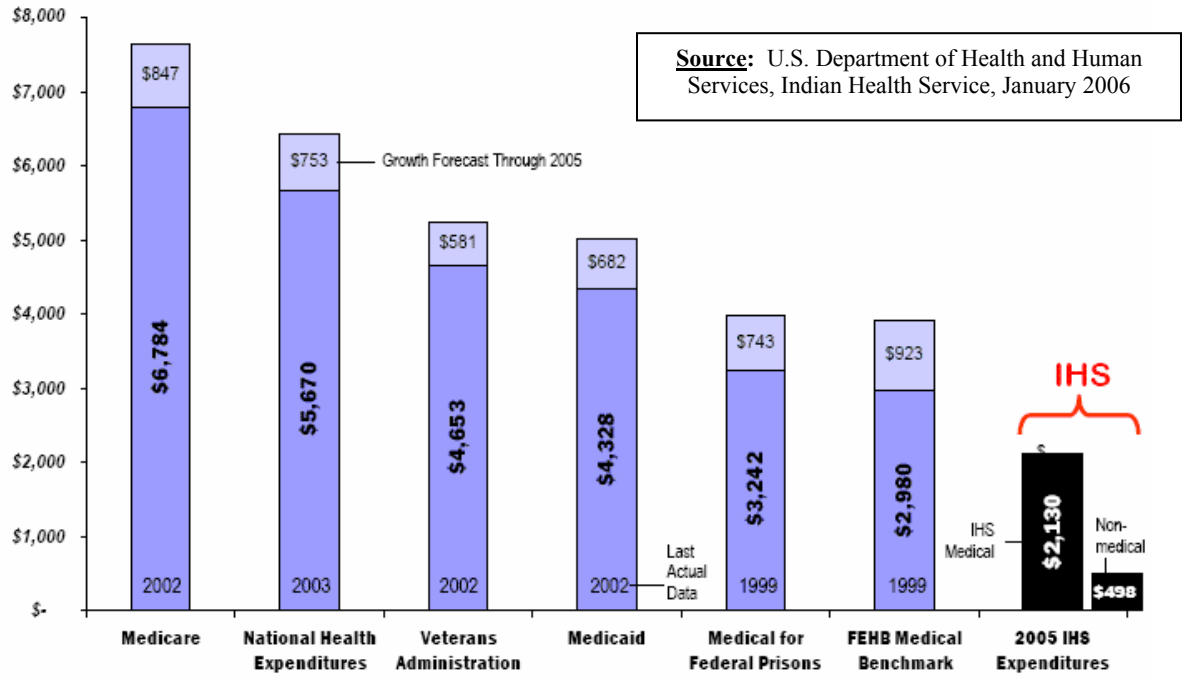
A brief review of the structure and funding of health care for Native Americans provides a clearer understanding of the current service delivery system. In addition to the more frequently discussed social and cultural factors, structural and financial factors play a major role in adequate health care delivery and, for Native Americans, have the potential to either improve the process or contribute to significant health care disparities.

The U.S. responsibility to provide health care to Native Americans originated very early in the history of this country as a result of treaty obligations to the tribes. Initially the federal government provided limited health services. In 1832, however, Congress began appropriating funds for health programs for all Native Americans. Currently, Indian Health Services (IHS), a federally funded service within the Department of Health and Human Services, is responsible for delivering health services to Native Americans.

IHS is the principal federal health care provider and advocate for Native Americans who are enrolled with a federally recognized tribe. Native Americans living on or near reservations, particularly in rural areas, are the primary recipients of services. Nearly one million Native Americans are not enrolled with a federally recognized tribe and, thus, are not eligible for these benefits.

Because IHS is a federally funded service and not an insurance program, funds are discretionary and not a personal entitlement. Consequently, IHS can provide health care services only to the extent appropriated funding allows. As shown below, when IHS funding is compared with that of other federal programs, annual per capita expenditures for Native American health care fall noticeably below those dedicated to other federal programs.

2005 IHS Expenditures Per Capita Compared to Other Federal Health Expenditure Benchmarks



Nationwide, twelve regional IHS offices administrate program operations (e.g., distribute funds, offer technical support), branch out to local administrative units and, ultimately, multiple direct health care facilities (e.g., clinics, hospitals). Arizona is home to three of these offices (Navajo IHS, Phoenix IHS, and Tucson IHS). Additionally, Arizona is fortunate to claim over 20 Indian Health facilities, including one of the nation's major Native American Medical Centers.

Within this system, tribes may elect to have IHS administer their health services directly or, as a result of the Indian Self-Determination and Education Assistance Act (PL 93-638) that created "638" facilities, they may choose to deliver the services to their own communities via contracts or compacts. Both direct and tribal programs use the Contract Health Service (CHS) Program to offer services that are unavailable at IHS and tribal facilities. However, eligibility for CHS requires that the recipient live on a reservation located within a CHS Delivery Area or live within a CHS Delivery Area and either be a member of or maintain close socio-economic ties with the tribe on that reservation.

Role of Medicaid

Native Americans who meet Medicaid categorical and financial eligibility criteria are entitled to coverage. This is the case whether a Native American lives on or off a reservation and whether or not he is eligible for IHS, Tribal, or Urban (I/T/U) services. In cases where an individual is eligible for both Medicaid and IHS services, Medicaid is required to assume responsibility for payment. When a Medicaid recipient receives a service provided by IHS that is not covered by the Medicaid benefit package, IHS, as the residual program, is responsible for payment.

Medicaid is an entitlement program for which the federal government matches, on an open-ended basis, state expenditures for covered services provided to eligible individuals. For Native American beneficiaries, the federal matching rate is generally 100% for services provided in an IHS facility and, at present, non-IHS Medicaid services are subject to the standard Medicaid match for Arizona. State Children's Health Insurance Program (SCHIP) or KidsCare services are provided at the standard SCHIP Federal Medical Assistance Percentage regardless of venue. Native Americans enrolled in KidsCare are not subject to monthly premiums or co-payments. Although a number of states operate managed care Medicaid programs, Native Americans are not required to enroll in non-IHS/Tribal contracted managed care plans.

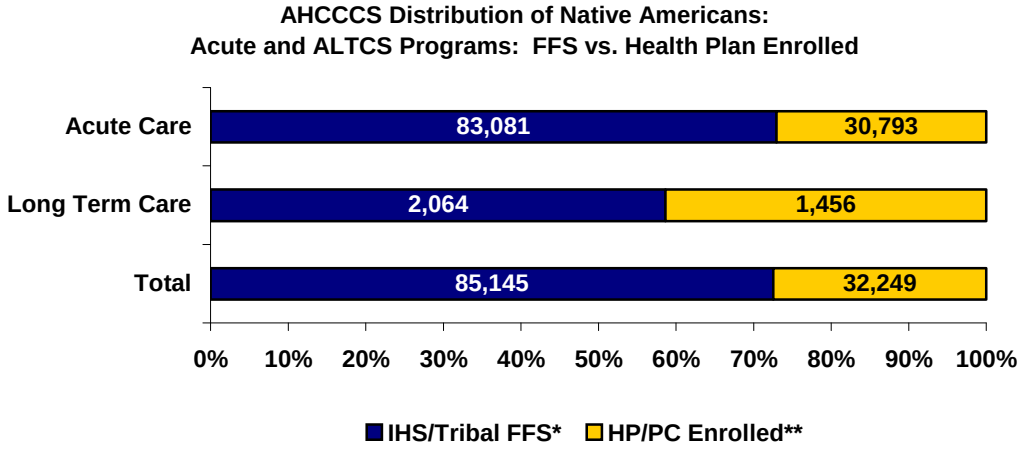
It is important to note that the Tribal Technical Advisory Group to the Centers for Medicare and Medicaid Services (CMS) is currently developing a five-year strategic plan for the purpose of improving the health of Native Americans by improving access to Medicare and Medicaid programs. Issues identified as most urgent include: (1) a need to improve the capacity of CMS to develop policies that work in Indian Country, (2) implementation of the Medicare Modernization Act (MMA), and (3) Medicaid reform. AHCCCS strategies should support these issues.

Significance to AHCCCS

AHCCCS services are increasingly important to Native Americans. Although Native Americans have traditionally relied upon IHS for their care, we have indicated that public programs, such as Medicare and Medicaid, are playing increasingly important roles. These programs support the delivery and financing of health services to individuals residing on or near reservations, as well as to those living in urban areas. As a state Medicaid program serving one of the largest Native American populations in the country, AHCCCS serves as:

- An insurance program that covers acute care, including physician, hospital, and other basic health care services for eligible individuals, especially families with children;
- An insurance program that covers behavioral health care, including physician, hospital, therapy, and other basic mental health care services for eligible individuals, especially families with children;
- An insurance program that covers long term care, including physician, hospital, nursing home, and other basic health care services for eligible individuals, especially frail elderly and disabled individuals;
- A source of payment for Indian Health Services (IHS) as well as clinics and hospitals operated by tribes; and
- A source of financial assistance for low-income elderly and disabled individuals in need of assistance to meet Medicare premium and cost-sharing obligations.

AHCCCS has received national recognition for its Medicaid managed care model, which delivers care via contracts with acute care health plans and long-term care program contractors. However, it also supports a fee-for-service program that approves and pays for services provided to AHCCCS members who are not enrolled with a contracted health plan or program contractor. Native Americans comprise the majority of this fee-for-service population. This is because AHCCCS enrollment policy allows them an initial choice of enrolling with either a contracted health plan or the IHS/AHCCCS Fee-for-Service (FFS) Program. Further, Native Americans who select to enroll in contracted health plans are also allowed to seek and receive care from an IHS facility if and when they choose.



* IHS/Tribal FFS = Enrolled with IHS or Tribal Provider – Reimbursed Fee for Service
** HP/PC Enrolled = Enrolled with Contracted Health Plan or Program Contractor
Data as of December 1, 2007

The above figure illustrates that the majority of Native Americans, particularly those in acute care, enroll in the IHS/AHCCCS FFS program rather than with a contracted health plan or program contractor. This FFS program population, plus the managed care plan enrollees who seek care outside their assigned plan (i.e., from IHS), encounter ongoing challenges related to availability of providers and continuity of care.

Tribal Consultation

A unique government-to-government relationship exists among Indian tribes and federal and state governments. The United States recognizes Tribal Governments as sovereign nations and has enacted numerous regulations that establish and define a trust relationship with Indian tribes. As a state agency responsible for administering a federal program, these regulations play a significant role in the way AHCCCS communicates with tribes in Arizona.

AHCCCS is the health care insurance provider for nearly half of Arizona's Native American population. The involvement of Indian tribes in the development of AHCCCS policy allows for locally-relevant and culturally-appropriate approaches to important issues. Pursuant to Executive Order 2006-14, "Consultation and Cooperation with Arizona Tribes," AHCCCS has developed and implemented a tribal consultation policy to guide dialogue with Indian tribes in

Arizona regarding high-level policy changes that may significantly affect them. AHCCCS and Indian tribes share a mutual desire to improve accessibility to quality health care for Native American AHCCCS members.

Goals, Key Issues, and Strategies

The following are identified as goals of the Native American Health Initiative (NAHI):

- Improve Native American health status within state/federal policy and guidelines
- Expand dialogue, partnerships, and collaboration with I/T/Us (Indian Health Service/Tribes/Urban Indian Clinics)
- Ensure correct reimbursement to IHS/638 facilities through appropriate billing for covered services, resulting in expanded, enhanced, and improved services

As the health care insurance provider for 48% of Arizona's Native American population, AHCCCS identified three key issues or areas of opportunity that deserve attention in this initiative:

(1) Unique Health Care Needs,

(2) Availability and Accessibility of Care, and

(3) Health Care Information Exchange.

These three issues impact and are impacted by the overarching issues or imperatives of the AHCCCS strategic plan: control medical cost inflation, improve health care quality and accessibility, reduce the volume of uninsured, and focus on organizational capacity. These latter four issues should guide current and future policy and program responses to the three key Native American health care issues also identified here.

Furthermore, and in response to the three key issues identified, AHCCCS convened a comprehensive representation of IHS and tribal health care providers to assess their willingness to partner with AHCCCS to address the issues. The initial response was positive, and future collaboration efforts may include the strategies following the presentation of each issue.

Unique Health Care Needs

The health status of Native Americans is illustrated by higher rates of disease and shorter life expectancy than the general population. As explained previously, a variety of conditions are responsible for the high morbidity and mortality rates. Some are directly affected by individual lifestyle. Some are interrelated in such a way that addressing one condition will impact the course of others, suggesting the long-range significance of early intervention (e.g., attention to obesity may lead to a reduction in the incidence of Type II diabetes and, ultimately, prevention of end stage renal disease).

Currently AHCCCS health plans and program contractors engage in a variety of quality management activities to identify and manage high-risk members, including those with conditions prevalent among Native Americans. Currently AHCCCS requires plans to conduct a health status assessment of all new members. For most plans, this process takes the form of a

survey, which assists in the early identification and management of conditions that have the potential to benefit from early intervention.

Whereas Native Americans enrolled in acute care health plans may benefit from identification and management strategies such as the one described above, individuals who select to enroll with the IHS/AHCCCS FFS program may forgo some of these advantages. This is because the AHCCCS Division of Fee-for-Service Management (DFSM), which provides oversight of the FFS population not enrolled in a contracted plan, is currently an administrative operation that does not offer disease management services.

Recommended Strategies:

- Collaborate with I/T/Us to identify opportunities to develop and expand culturally-sensitive disease management programs for Native Americans.
- Investigate opportunities for improving the integration of services for Native Americans in the IHS/AHCCCS FFS program.
- Develop regular utilization and quality indicator reports that inform outreach efforts and disease management activities among Native Americans with high-risk conditions.
- Support efforts to educate I/T/U providers regarding provisions of the Medicare Modernization Act (MMA) that relate to Native American health care, particularly those that involve the transition of dual eligible members from Medicaid to Medicare.

Availability and Accessibility of Care

A variety of barriers limit the availability and accessibility of health care to Native Americans. These barriers, whether social, cultural, structural, or financial, affect individuals who receive care from AHCCCS and/or those who do not.

Medicaid and SCHIP Enrollment Issues: Despite eligibility for AHCCCS coverage, a percentage of Native Americans choose not to enroll. The lack of willingness to enroll may result from their understanding, based on past treaties and obligations, that the federal government is required to provide health care without regulations or limitations. They may be uncomfortable with requests for private information, lack trust in federal programs, or be unable or unwilling to produce the documentation that must accompany the application. The process may simply confuse them, or they may lack the transportation to complete applications.

The current insufficiency of IHS funding levels and the geographical criteria for Native American use of IHS services create a need to transcend the barriers and increase enrollment in public health insurance programs such as Medicaid and SCHIP. By enrolling in these programs, Native Americans give the I/T/U system—or Indian Health Service/Tribes/Urban Indian Clinics— an opportunity to bill Medicaid or SCHIP for the cost of services and expand their network of health care providers. Obviously this means that I/T/U sites must support a billing infrastructure.

AHCCCS Structure: As previously explained, the AHCCCS structure allows Native Americans to enroll in a contracted health plan or to enroll in the IHS/AHCCCS FFS program. AHCCCS authorizes services and pays claims for Native Americans who are enrolled in the FFS program rather than an AHCCCS-contracted health plan, and for those who are enrolled in a contracted

health plan but seek care through the I/T/U system. This administrative arrangement does not support the provision of care continuity and case or disease management.

Network Issues: AHCCCS relies upon a fee-for-service network to provide services, not only to the Native American population enrolled in the IHS/AHCCCS FFS program, but also to individuals who qualify for the state's Federal Emergency Services (FES) program. It is, therefore, a consistent challenge to maintain a fee-for-service network that is available, accessible, and culturally competent to serve the specific needs of Native Americans. Difficulties surrounding service integration and health management for members outside a contracted managed care plan compound the circumstances.

Recommended Strategies:

- Develop and support strategies to improve enrollment of Native Americans in AHCCCS, such as streamlining application processes and supporting more enrollment representatives in I/T/U facilities.
- Via marketing and education strategies, put a "face" on the IHS/AHCCCS FFS program that can be identified by members and providers.
- Reduce administrative barriers to care.
- Collaborate with IHS and the tribes to identify, recruit, and retain a network of preferred providers available to care for the fee-for-service Native American population.
- Proactively engage a preferred provider network through incentives and educational opportunities that include cultural competency training.
- Support development of tribal operations infrastructure in order to enhance the management of health care services.
- Support efforts to improve availability of telemedicine for communities in remote areas.

Data Needs and Information Exchange

Fragmentation of health care data can create significant barriers to effective and efficient care delivery. Information systems should be capable of sustaining administrative functions and continuity of care. They should also be capable of supporting effective data collection for purposes of disease management, evidence-based treatment processes, and community health studies.

The current IHS information system requires enhancements to meet the above criteria. The methodology for claims and encounter reporting between IHS and AHCCCS does not detail procedure information that allows for informed decision-making. Another drawback results from a lack of data coordination and reporting between IHS and independent tribes. As a result of tribal autonomy, not all tribes contribute health data to IHS. This affects the availability and accuracy of information on overall Native American health status as well as program administration and funding.

When complete and accurate health data are not collected and reported to a central repository, trends in disease incidence, prevention, and treatment are under-reported and may, in the long run, impede progress in eliminating health disparities. Innovative short and long term solutions are necessary to improve ultimate health outcomes.

The current billing and payment structure between AHCCCS and IHS does not support the collection of utilization data. At the present time, IHS and 638 facilities are reimbursed at a set rate, published in the federal register, for either inpatient or outpatient services. This method of billing does not capture the actual services provided. Consequently, it is not possible to generate utilization reports from the current reporting systems. Without details of the services delivered, tribes cannot analyze utilization patterns or identify opportunities to improve the management of member care. Standardized data collection would assist tribes wishing to develop reports and track service utilization and actual costs.

Recommended Strategies:

- Support the gathering and evaluation of health information to facilitate disease management and outcome research, and to inform Native American health policies and initiatives.
- Enhance data collection efforts for the purpose of developing tribal utilization reports that facilitate the health care management of members and the identification of patterns of care and, ultimately, network needs.
- Encourage I/T/U facilities in Arizona to participate as data partners of AZ HealthQuery (AZHQ), a statewide database created to facilitate continuity of individual health information across time and delivery systems. AZHQ supports effective disease management and outcomes-based treatment programs, and contributes to public health information.
- Support the development of an IHS electronic record system, and identify opportunities for collaboration.
- Enhance IT capabilities and reporting processes to produce patient data by ethnicity.

RESOURCES:

Agency for Healthcare Research and Quality. *Managing Care for Adults with Chronic Conditions.* Retrieved December 2006. www.ahrq.gov/news/ulp/chronic/ulpchron1.htm

American Cancer Society. (2004).*Cancer Facts & Figures 2004.*

Annie E. Casey Foundation. (2006). *Kids Count Data Book: State Profiles of Child Well-Being*.

Arias, D. (June 2004). *Vision Loss an Increasing Public Health Problem.* Medscape from WebMD.

The Arizona Association of Community Health Centers Online. Retrieved December 2006. www.aachc.org.

Arizona Asthma Coalition (2006). *Breathing Easier in Arizona: An Action Plan for Change. Page 2.*

Arizona Department of Economic Security Online. Retrieved December 2006. www.de.state.az.us.

Arizona Department of Health Services. (2004). *Arizona Health Status and Vital Statistics 2004.*

Arizona Department of Health Services. (2007). *Prostate Cancer Fact Sheet.*

Arizona Governor's Office on Aging. (May 2004). *Aging 2020 Summit*.

Arizona Hospital and Healthcare Association. (December 3, 2004). *U.S., Arizona Uncompensated Care Rising, Data Show*. Weekly Newsletter Vol. 18 No. 45.

The Arizona Telemedicine Program Online. Retrieved December 2004. www.telemedicine.arizona.edu.

California HealthCare Foundation. (2006). *Snapshot: Heath Care Cost 101*.

Centers for Disease Control and Prevention Online. Retrieved December 2006. www.cdc.gov.

Centers for Disease Control and Prevention. *State Cancer Burden for Arizona.* Retrieved December 2006. www.cdc.gov/cancer/CancerBurden/az.htm.

Centers for Medicare and Medicaid Services, Office of the Actuary Online. *National Health Care Expenditures Projections: 2005-2015*, Retrieved December 2005. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf

Resources

Centers for Medicare and Medicaid Services, Office of the Actuary Online. *National Health Statistics Group*, Retrieved November 2007. http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2005.pdf

Children's Trends Data Bank. *Overweight Children and Youth.* Retrieved December 2006. www.childrenstrendsdatabank.org/indicators/15OverqeightChildrenYouth.cfm.

David A Kindig, MD, PhD. (2006). *A Pay-for-Population Health Performance System*. Page 24.

Friedland, R.B. (July 2004). *Caregivers and long-term care needs in the 21st century: Will public policy meet the challenge?* Georgetown Long-Term Care Financing Project.

Harris Management Group. (2004). *Trends in Arizona Medicine: 2004 Survey Results.*

Healthcare Group of Arizona. Enrollment *and Demographic Data (as of November 2006)*. Retrieved December 2006. www.healthcaregroupaz.com.

Healthy Americans (2006). *Obesity Report in Arizona 2006*. Retrieved November 2006. www.healthyamericans.org/reports/obesity2006

Healthy NY Program Online. Retrieved December 2005. www.ins.state.ny.us/healthyny.htm.

Integrated Healthcare Association. (August 9, 2004). *IHA Pay for Performance California Initiative Evaluates 215 Medical Groups for Reward and Recognition by Health Plans.*

Kaiser Family Foundation and Health Research and Educational Trust (2006). *Employer Health Benefits: 2007 Annual Survey.* Page 1.

Kaiser Family Foundation Snapshots: Health Care Costs. Comparing Projected Growth in Health Care Expenditures and the Economy. May 2006. www.kff.org/insurance/snapshot/chcm050206oth2.cfm

Kaiser Commission on Medicaid and the Uninsured. (October 2007). *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008.*

Kaiser Commission on Medicaid and the Uninsured and Health Management Associates. (October 2006). *Low Medicaid Spending Growth Amid Rebounding State Revenues*.

Kaiser Commission on Medicaid and the Uninsured (October 10, 2007). *Medicaid Enrollment Declines for the First Time in Nearly a Decade: States are Planning to Expand Coverage for Uninsured. Retrieved November 2007.* www.kff.org/medicaid/kcmu101007nr.cfm.

Kasiernetwork.org. (2004). *Press Conference: 2004 State of Health Care Quality Report: September 23, 2004*.

Kaiser State Health Facts Online. Retrieved December 2007. www.statehealthfacts.kff.org.

Medical Expenditure Panel Survey Online. Retrieved December 2004. www.meps.ahrq.gov.

Medical News Today. (July 2006). Diabetes Disease-management Programs Improve Quality of Care Research Finds. Retrieved December 2006. www.medicalnewstoday.com

Moses, S. (September 2004). *The Long-Term Care Dilemma: What States Are Doing Right - and Wrong*. Council for Affordable Health Insurance, Alexandria, VA and American Legislative Exchange Council.

National Coalition on Health Care Online. *Facts on the Cost of Health Care.* Retrieved December 2006. www.nchc.org/facts/cost.shtml

National Coalition on Health Care Online. *Health Insurance Cost.* Retrieved November 2007. www.nchc.org/facts/quality.shtml

National Coalition on Health Care Online. *Health Insurance Quality.* Retrieved December 2007. www.nchc.org/facts/cost.shtml

National Committee for Quality Assurance. (2004). *The State of Health Care Quality 2004, Industry Trends and Analysis*.

National Governors Association Center for Best Practices. (2004). *A Lifetime of Health and Dignity: 20 Actions Governors Can Take*.

Pima Community Access Program Online. Retrieved December 2005. www.pacap.cc/index.html.

RIte Care, Rhode Island Department of Health Services Online. Retrieved December 2004. www.dhs.state.ri..us/dhs/famchild/shcare.htm.

Smith, C., C. Cowan, A. Sensenig and A. Catlin. *National Health Spending in 2004.* Health Affairs 25:1 (2006): 186-196.

State Coverage Initiatives and Academy Health. (January 2004). *State of the States: Cultivating Hope in Rough Terrain.*

St. Luke's Health Initiatives. (December 2006). *Health Bullets*. Arizona Health Futures Project.

Texas State Auditor's Office. *Workforce Planning Guide*. www.hr.state.tx.us/worforce/guide.

United Health Foundation. (2004 Edition). *America's Health: State Health Rankings, A Call to Action for People & Their Communities*.

Resources

U.S. Congressional Budget Office. (April 2004). *Financing Long-Term Care for the Elderly: A CBO Paper*.

U.S. Department of Health and Human Services Office of Human Resources. *Workforce Planning Resource Guide*. www.hhs.gov.ohr/workforce.

U.S. Census Bureau Online. Retrieved December 2006. www.census.gov.

U.S. Office of Personnel Management (OPM). *Workforce Planning Model*. www.opm.gov/workforce planning.